A Process Evaluation

of the

Growing Together Program

A Study Funded by
the Invest in Kids
Foundation

Growing Together, Toronto, Ontario

A collaborative project sponsored by
the Hincks-Dellcrest Centre and
the Toronto Public Health Department

A Process Evaluation

of the

Growing Together Program

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Growing Together - A collaborative project sponsored by
the Hincks-Dellcrest Centre and
the Toronto Public Health Department

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Executive Summary

Between September of 1996 and September of 1998 the Growing Together (G.T.) research team carried out an internal, process and short-term impact evaluation study of the Toronto based Growing Together program a prevention, early intervention and health promotion program in St. Jamestown. The following report deals exclusively with the findings of the Process Evaluation which was designed to facilitate program planning and development.

The study involved a one year (1996), retrospective examination of the program's activities, procedures and routines. It used process data gathered from the Growing Together Management Information System (MIS); case files; and semi-structured interviews with G.T. workers, local community providers and Growing Together clients.

The study found the following services to be particularly effective, both in terms of reaching families and client satisfaction:

- Contacting new mothers living in St. Jamestown, soon after birth is being successfully accomplished. The use of birth notices was the most successful method, while follow up by the Growing Together intake worker has been useful in enabling families to become involved in various program components.

- Other parents join the program by self-referral, referral through an outside agency, and other or untraceable means. In 1996 there was a total participation rate of 477 families and 543 children.

- At entry into the program approximately one-half of the families who join complete a Risk Factor Assessment (RFA) interview. This allows for collection of background and intake information and assessment of the level of risk and needs of families. This facilitates the process of referring parents to optimum services to meet their needs. These range from the most intensive clinical/ counselling interventions to informational and practical groups.

- Clients who received counselling and therapy sessions from the G.T. program found they met a number of their needs such as: alleviating feelings of loneliness and isolation, education and teaching about health and developmental issues.

- G.T. groups are well used and were attended by 229 participants in 1996. Childcare services while parents attended groups were provided for 166 children.

- A recognized and valued service involves the tracking and monitoring of the development of infants and young children through the Infant Monitoring System (IMS) and the Developmental Clinic. In 1996, 128 children were seen at the Developmental Clinic and currently over 200 children are being monitored through the IMS.

- Community Development initiatives complement the other work being carried out by G.T. and provide valuable experiences for parents. Community members play an increasingly important role in the planning and operation of community events and initiatives. Listening to community members and integrating their ideas into programming directions is a priority of the program.

- Advocacy services are a very important aspect of the program with 134 families having been referred to the advocacy specialist in 1996.

- Services are provided by a multidisciplinary team; students from various disciplines and volunteers from St. Jamestown and other areas of the city. The varied education, background and experience of the G.T. team enable it to meet the multiple and complex needs of G.T. families.

Based on the findings of the Process Evaluation Study recommendations were as follows:

1. That the following services and program components should continue to be considered and supported as essential components of the program: maintaining of a community site, telephoning and offering immediate services to new mothers on receipt of Birth Registration Notices (BRNs); home visiting as an outreach strategy; the tracking of infants and young children through the Infant Monitoring System and Developmental Clinic; groups; and community initiatives.

2. That efforts be made to secure sufficient and stable finding to ensure that the key components of the program (see 1 above) be adequately maintained.

3. That the Growing Together team continues to have representatives from various disciplines as well as community home visitors from St. Jamestown, and students and volunteers.

4. That various procedure and policy issues be discussed and further developed including, for example research directions and program feedback procedures.

5. That efforts for program promotion continue and be further explored.

6. That consideration be given to the collection of certain types of data, as well as the design and development of new forms to address database gaps.

The information from this process evaluation has confirmed that the program components of the model are meeting the needs of families and are well accepted by workers. Study recommendations will increase the program's capacity to maintain adequate records of the various families that use the program and the interventions that they receive.

Acknowledgements

This project was funded by the *Invest in Kids Foundation* and supported by *the Hincks-Dellcrest Centre* and the *Toronto Public Health Department*. *The Invest in Kids Foundation*, supplied the project with a full-time research coordinator, a part-time research assistant and, as well funded the printing of this report.

The Growing Together research team, which oversaw the project, was made up of members from both the *Hincks-Dellcrest Centre* and the *Toronto Public Health Department.* Sarah Landy was responsible for the overall supervision of the project. Joyce Radford coordinated the study and prepared the report. Kwok Kwan Tam was responsible for computer programming, data entry and analysis, organizing the Management Information System data, and developing the figures and tables which appear in the report. Nikki Martyn helped develop data collection instruments and research materials, conducted interviews with Growing Together volunteers and clients, and assisted with case file reviews. Ken Leang was involved in data entry, interviewed students on placement at Growing Together as well as clients, and assisted with the Developmental Clinic file review. Remaining Growing Together research team members met bi-monthly and, provided feedback about the study and assisted with report preparation. Thanks to team members: Joanne Cooper, Susan Dundas, Corinne Hart, Denise Martyn, Susan Mockler, Anne-Siri Oyen, Zoë Tate, Michelle Weiss.

An Advisory Group consisting of members from the *Invest in Kids Foundation*, the *Hincks-Dellcrest Centre*, and the *Toronto Public Health Department* came together every three to four months to be appraised of project status and advise on report preparation and dissemination. Our appreciation goes out to Advisory Group members: Lorraine Bodnaryk, Nancy Cohen, Chaya Kulkarni, Lorraine Loeb, Sara McColl, Freda Martin, and Carol Crill Russell.

Case file reviews were conducted with the co-operation of the *Toronto Public Health Department* and the *Hincks-Dellcrest Centre*. Fundamental to the successful completion of an extensive DPH file review was the assistance of Lorraine Bodnaryk (DPH Manager and G.T. Co-Director) and Joanne Cooper (DPH Manager), along with the efforts of clerks Angie Pieroni, Marie McCallum, Lianne Butts and Mary Helen Surmachynski.

Staff, students, and volunteers of the Growing Together program were highly committed to the project and are thanked for speaking candidly during meetings and interviews about their work and activities at Growing Together. We are also grateful to those community service people

who were interviewed at: Victoria Day Care Centre; Rose Avenue Public School; Rose Avenue Community Centre; St. Jamestown Health Centre; Metro CAS; and 519 Church Street Community Centre. Finally a special appreciation is extended to Growing Together clients whose unique and critical perspective provided invaluable information about the services of our program.

Photographs which appear throughout the report were taken by Lennox White of the Hincks-Dellcrest Centre with a few having been provided by G.T. workers. Computer scanning of photos was done by Stacey Baines.

We are grateful to all those involved with the *Process Evaluation Study* for their effort and support.

SL
JR
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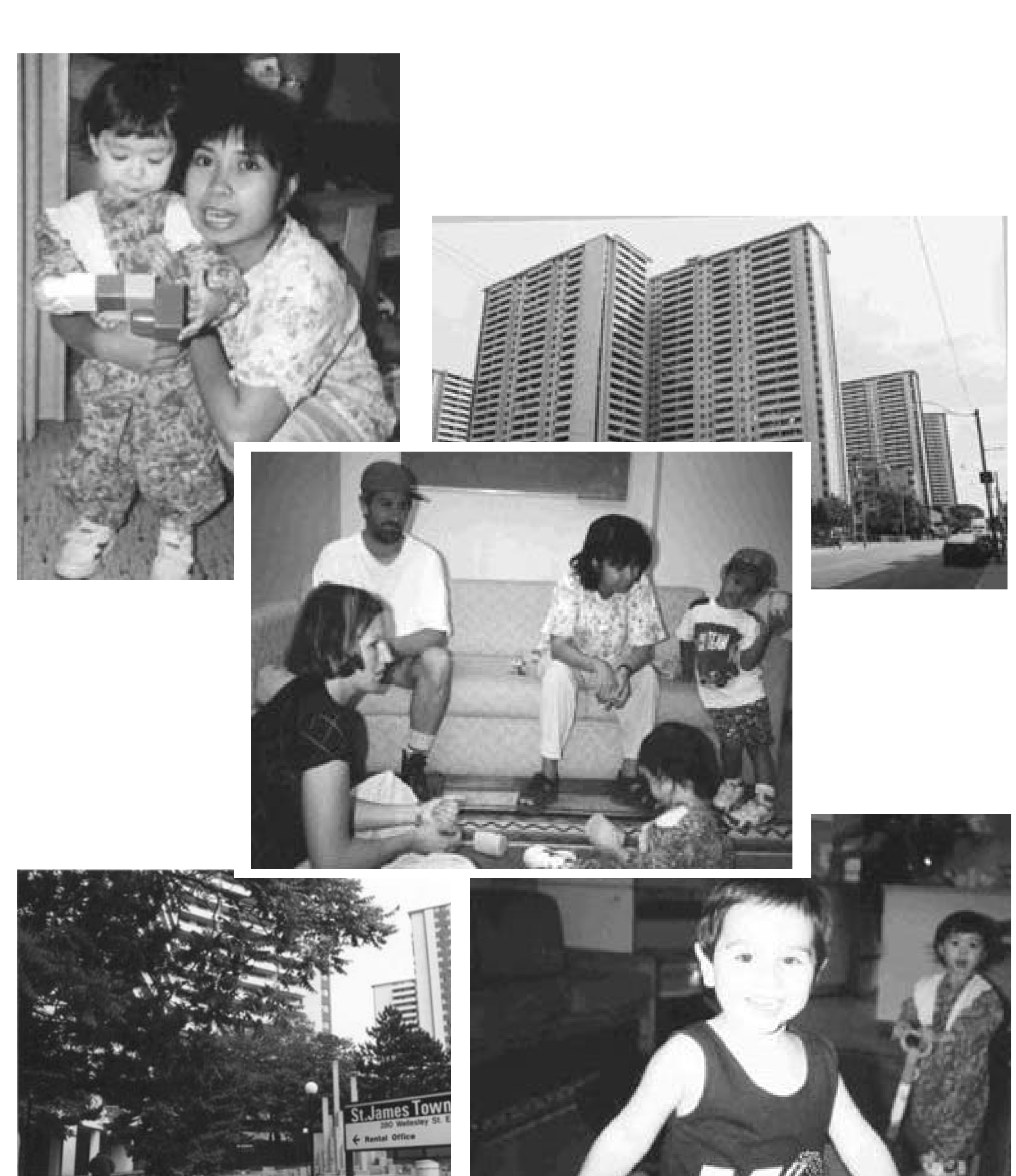
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I Introduction

1.1 Purpose of the Study

The Growing Together (G.T.) Program, which officially opened in October 1993, offers health promotion, prevention, and early intervention services to families with children under the age of five. A population-based, prevention and early intervention initiative, program staff direct their efforts toward:

1) health promotion strategies and preventing future health problems in both parents and children; and,

2) intervening early in situations where the development of an infant or child is at risk due to direct circumstances or potentially at risk because of a parent's behaviour or life situation.

Promotion of the health and well-being of infants, young children, their families, and the community, is the overall objective of the Growing Together program.[1]

[1] For a thorough review of the program's goal, objectives and theoretical basis, refer to the *Short-term Impact Evaluation of the Growing Together Program* (Chapter I).

Population-based, prevention and early intervention programs

Early intervention programs are directed at increasing the competence of children with some known risk or disability.
Crnic & Stormshak, 1997, p. 209

Population-based strategies are designed to affect the entire population. Clinical approaches [on the other hand] deal with individuals one at a time, usually individuals who already have a problem or are at significant risk of developing one.
Ministers of Health, 1994, p. 1.

Prevention programs operate at the level of primary and secondary prevention. These range from broadly targeted low-investment efforts such as telephone hotlines and public service announcements on television -- to those that actively target and engage high risk populations for the specific purpose of preventing compromised development.
Barnett, 1997, p. 152.

Primary prevention works on preventing medium risk families or persons from becoming high-risk. A small shift in the mean risk score for the community as a whole will have a large effect in reducing the number of families that fall in the high risk end. ... An approach that responds only to the high-risk end of the continuum will not have as much long-range impact on problem reduction as a community-wide program. ... The problem with a community-wide approach, however, is that it is complicated to conduct, requires the expenditure of public funds, and often requires a number of years to show results.
Chamberlain, 1992, p. 66.

A transactional theoretical model guides the G.T. program

In the transactional model, the child is seen to develop through the continuous interaction of multiple influences, some of which arise within the child, including such factors as biological or temperamental disposition. Factors outside the child that influence development include characteristics of the parents and larger family, as well as the community, culture and society. The interactions of these factors are multidirectional, and the whole is greater than the sum of the parts. ... The model was based on an extensive review of the literature, the needs of families in the area and an intensive planning process that took place over a number of months. In such a model, isolating one factor as a target for intervention is unlikely to be successful. Therefore, Growing Together addresses multiple levels of factors at each stage of program implementation. Multifactor risk assessments are carried out for each family in order to select interventions that target the particular factors most important at that point in time for that family.
Landy & Cooper, 1995, p. 10.

Operating in the community of St. Jamestown, in the city of Toronto, the program is located in a neighbourhood which, in general, can be characterized as having key factors known to place children at risk for compromised development. In 1991, there were 22,715 people living in the area (City of Toronto, Public Health Department, 1995), making it one of the highest population densities in Canada (Allaby, 1987). Birth and fertility rates are double that of the rest of Toronto and the median family income is $30,262 compared with $47,062 for Toronto. Beyond high density and poverty, other characteristics which place children of this community at risk include: a high per capita crime rate (Metropolitan Police Annual Report, 1990, 1991) and prevalent drug use and drug related crime (Mayor's Task Force on Drugs, 1990, 1991).

At-risk families seen at Growing Together tend to fall into three categories: 1) new immigrant families who may be isolated and disenfranchised because of leaving behind their relatives and homelands; 2) families experiencing difficulties because they have a child with a developmental delay or a parent or child suffering from a serious medical problem; and, 3) families who face multiple challenges and have often experienced severe abuse, trauma and/or loss, across past generations. At times, families fall into more than one of these categories.

Appropriate interventions are selected for each family according to the type and degree of risk

identified. Individual, family, group and community approaches are all offered to Growing Together families. Aspects of the program are available whether families are at risk or not. Services for no or low risk families, include an infant tracking system, parenting classes, computer training classes, a Developmental Clinic, English classes, as well as art and craft classes. Multidimensional programs such as this are extremely complex; offered to populations with varying and multiple needs, programs must be adapted according to their relevance and adequacy to provide high quality effective services to the community. Consequently, it is essential to understand both the content of each service component area, how different components fit together, and their acceptability to the population to which they are offered. Furthermore, there is the question of whether the program team is able to effectively operate within the existing system and achieve the desired program objectives.

In complex, multi-strategy programs, process evaluation can provide feedback to practitioners for the purpose of improving program operations. Used as an initial step in program evaluation, process evaluation provides information about the program's activities, and patterns of service utilization. Conducting this level of evaluation after a program has operated for a long enough period in relatively stable conditions is critically important in order both to enhance current program functioning and recommend future program directions.

The value of process evaluation

Process research can illuminate the ways in which support and services are provided and utilised within a program context ... what services are provided, by whom, to what types of families and what are the patterns of service utilisation.
Powell, 1987, p. 327

Three key reasons for conducting a Process Evaluation of the Growing Together program were:

1. To inform Growing Together managers, funders, and workers about the overall operational quality of the program, and to guide future program development.

2. To share with other Growing Together sites, located across Canada, those program components and procedures deemed critical for successful program operation.

3. To steer those conducting research in the field toward feasible evaluation designs and methods, while advancing their understanding of the challenges involved in studying these multidimensional programs.

1.2 Early Intervention Programs

1.2.1 The societal context for early intervention programs

Today, in both Canada and the United States, children face increasing levels of poverty while their parents experience less access to necessary services such as affordable housing, welfare, child care subsidies and community support (Steinhauer, 1996). In many high risk neighbourhoods, such as St. Jamestown, families are more likely to be unemployed or under-employed and to have an income level far below the national average. Many families are either headed by single parents or two wage earner parents with inadequate access to high quality, subsidized childcare. City neighbourhoods are often over crowded and offer few open green spaces or play areas for children. Crime, violence and drug addiction are prevalent (Halpern, 1993; Miller, Jackson, Johnson-Hacks, & Stone, 1995; Slaughter-Defoe, 1993). Such areas offer little opportunity for social support or incentive to become involved in the community. The rate of infant prematurity, chronic child illness, visits to emergency rooms and incidence of child abuse are also often significantly higher in these areas than in more middle class or affluent areas (Halpern, 1993). These characteristics have contributed to a proliferation of early intervention programs which incorporate a variety of strategies in order to meet the needs of families. Early Intervention Programs aim to enhance child development, parenting

Factors that place children at risk

Cognitive and social-emotional competence of children have been found to be strongly related to family mental health and especially social class. Efforts to prevent developmental dysfunctions must be based on an analysis of factors which impede the psychological development of children. These range from proximal variables like the mother's interaction with the child to such intermediate variables as the mother's mental health to distal variables such as the financial resources of the family. Although causal models have been sought in which singular variables uniquely determine aspects of child behaviour, a series of studies in a variety of domains have found that, except at the extremes of biological dysfunction, it is the number rather than the nature of risk factors that are the best determinants of outcomes.
Sameroff & Fiese, 1990, p.120

interactions and knowledge as well as improve parents' sense of competence and community support.

1.2.2 Two-generational programs

Serving children and parents

Two-generation programs seek to promote positive outcomes for both children and parents (hence "two-generation"); they try to help families escape poverty while simultaneously promoting child development and helping parents learn new parenting skills.
Gomby, Larner, Stevenson, Lewit, & Behrman, 1995, p. 9.

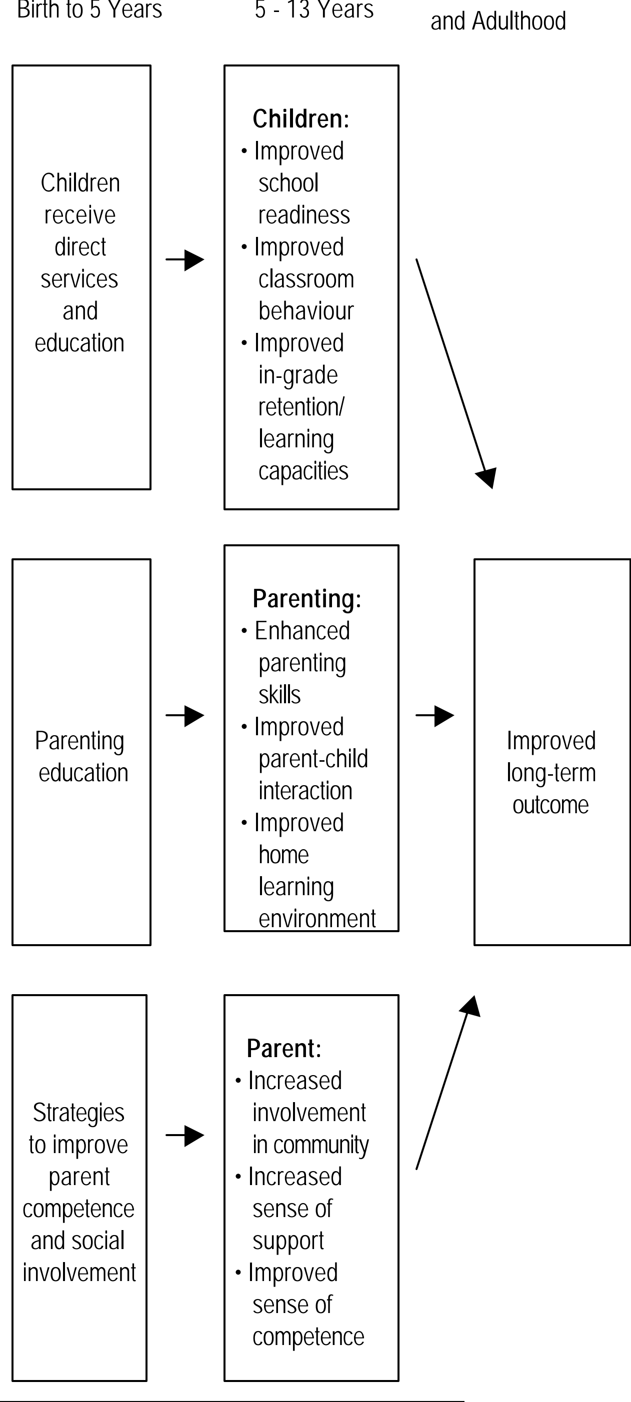
Two generation programs seek to solve the problems of parents and children in two contiguous generations by offering services such as early childhood education to help young people get the best possible start in life and at the same time, by offering services such as job training, literacy training and vocational education to help their parents become economically self-sufficient.
St. Pierre, Layzer, & Barnes,1995, p. 79.

Referred to at times as multi-strategy, multimodal or multidimensional programs, two-generational programs which target the child, parenting and parental competence, are relatively new additions to a broad array of early intervention programs designed to serve children and families. These programs grew out of the realization that single-focused approaches have not proved successful individually or even in combinations of two (Dust, Trivette, & Jodry, 1997; Crnic & Stormstank, 1997; St. Pierre, Layzer, & Barnes, 1995). Such programs have been a response to the recognition of the multidimensional, multigenerational aspects of family problems and a desire to attack them from multiple directions (Smith, 1991).

Under one program, the two-generation approach seeks to improve the life circumstances of two generations by offering services to children as well as enhancing parents' sense of competence and self-sufficiency (see Figure 1). Many of these programs provide counselling, crisis intervention, home visiting and other direct services. Others enroll families in existing outside services rather than creating duplicate service structures.

A great deal of variation exists in these programs in spite of these common characteristics. In general, two-generational programs are provided on a community-wide basis with all families in the area being eligible. This allows both the needs of high and low risk families to be addressed with lower risk families being offered less intense services (Chamberlain, 1988).

Figure 1
Early Intervention Services:
Expected Effect on Parents and Children



1.3 Process Evaluation

1.3.1 Early intervention programs and program evaluation

Although there has been a proliferation of early intervention programs, few evaluations have been carried out with sound experimental designs. Six programs which have been evaluated are: Child Family Resource Program (CFRP) (Travers, Nauta, & Irwin, 1982); Avance (Johnson & Walker, 1991); Comprehensive Child Development Program (CCDP) (St. Pierre, Goodson, Layzer, & Bernstein, 1994); Even Start (St. Pierre, Swartz, & Gamse, 1995); Head Start Family Centers (CFSC) (Swartz, Smith & Berghauer, 1994); and New Chance (Quint, Polit, Bos, & Cave, 1994). In these evaluation studies, researchers have measured the long-term outcome effects of the programs after five years. In general, the programs were shown to produce small or no improvements in child development but they did have positive effects on parenting. Positive outcomes have included: improved parent-child interactions; more time spent with the child; more emotional support for the child; and, improved attitudes to child rearing. Participants also increased their use of services but variables such as maternal depression or self-esteem showed little improvement. It was concluded by many of the evaluators that more research was needed on the links and integration between the approaches used because the flexibility of programming and the

The challenge of evaluating community programs

Evaluation of programs in whole communities requires special considerations and approaches. First, programs administered on a large scale cannot be as tightly organised as programs administered to a small group, making monitoring of implementation both necessary and challenging. Second, the fact that multiple component programs addressing a single health promotion issue (e.g. multiple programs designed to facilitate smoking cessation) are occurring simultaneously makes it difficult to assess the effects of any one program component. Third, the recipients of the programs are located throughout the community and may be poorly identified, making evaluation data collection complex and expensive. Finally, most community health promotion programs do not occur in a vacuum but rather co-exist with national and local programs, making it difficult to disentangle the effects of the program under consideration from the background of similar programs.
Pirie, Stone, Assaf, Flora, & Maschwsky-Schneider, 1994, p. 23.

community-based approach often made it difficult to determine the source of the program's effectiveness or lack of success.

As noted by Miller, Jackson, Johnson-Hocks and Stone (1995), in discussing the Beethoven project, which operates in an extremely high risk area of Chicago: "trial and error is often the only route when experts do not know the answer"(p.3). All service components must be subject to continuing adjustment as program organizers learn more about how to attract and deliver services to families in a particular neighbourhood. In other words, to return to Figure 1, it is important to understand in detail what is involved in each intervention component and how they fit together or can best be integrated.

Very little discussion of process evaluation or evidence of its use occurs in the literature on the evaluation of early intervention programs (Powell, 1987). Many conclude that what is missing from the evaluation of different kinds of early intervention programs is an understanding of how they are effective, with whom they are effective, and the process of change (Behrman, 1993; St. Pierre, Layzer, & Barnes, 1995; Weiss, 1993). Some of these questions are best addressed by a process evaluation which examines the operation of a program.

1.3.2 The Growing Together evaluation plan

Between September of 1996 and September of 1998 the Growing Together (G.T.) research team carried out an internal, Process and Short-Term Impact Evaluation Study of the Toronto based Growing Together program. In moving toward the objective of thoroughly evaluating the Growing Together program, an evaluation plan which includes four inter-related levels of evaluation was developed early on by the co-directors of Growing Together.

Appearing on the opposite page is Table 1 which provides an overview of the larger evaluation plan for the Growing Together program. The plan is a hierarchical model of program evaluation with lower levels of evaluation informing the design and interpretation of higher or subsequent levels. The plan was put in place in recognition of the fact that the quality of a program cannot be fully appreciated without first understanding how a program's process or operation influences the immediate or short-term impact of a program. Similarly, information about how a program operates and its effect on participants in the short-term, informs both the design and findings of a long-term outcome evaluation study. For this reason, it is recommended that impact and outcome evaluation not be carried out until process evaluation has been completed.

Benefits of an internal evaluation

... The risk of bias from program advocates who evaluate their own programs may be largely offset by the greater relevance and usefulness of their evaluation results. They are more likely to apply the results to the improvements of their own programs and practices if they conduct the evaluation themselves, or at least participate actively in it. ... The "experimenting practitioner" is devoted to the strengthening of the scientific base on which not only his or her own practice or programs are conducted but also on which the profession at large must build.

Green, & Lewis, 1986, p.20, 24.

Table 1
Overview of the Growing Together Evaluation Plan

Level of Evaluation	Time-Frame	Information Gained
<u>**Process Evaluation**</u> Involves the examination of the internal dynamics and operation of the program. COMPLETED	• one year of program operation • program process between Jan. 96 and Dec. 96 will be examined	• quality of each of the G.T. program components (i.e., intake) and areas for program development • program components and procedures that are critical for successful program operation • feasible evaluation designs and methods for studying multidimensional programs
<u>**Short-Term/ Immediate Evaluation**</u> Involves the examination of program impact soon after program intervention has occurred. Often involves looking at increases/ decreases in functioning (i.e., knowledge increase after psycho-educational group participation). COMPLETED	• one year study of client pre/post follow-up	• Short-Term impact of client participation in psycho-educational groups, developmental clinic, counselling and therapeutic treatment • minimal information will be available on the impact of the program on the child as the time frame is brief, and there is no comparison group • some understanding of the critical components necessary for program efficacy and replication will be available through interviews with staff and clients about the importance of different aspects of the program
<u>**Long-term Evaluation**</u> Involves examining those changes in the child, parent and community that the program hopes to achieve over time (e.g., improved functioning). FUNDING BEING SOUGHT TO CARRY OUT THIS LEVEL OF EVALUATION	• four year longitudinal client follow-up and comparison with a community sample • funding applications may need to consider evaluation of specific aspect of the program.	• change in selected outcome indicators measured over a four year period • comparisons between the program and community sample will allow for discussion of program outcome for child, parent, and community • longitudinal data and path analytic models will offer a greater understanding of those critical program components related to positive child outcome, and further inform program replication
<u>**Economic Evaluation**</u> Involves examination of the direct and indirect cost of G.T. in comparison with other initiatives that share similar objectives. The benefit-cost ratio will be	• comparison of community indicator statistics at the start and end of a one year period	• determine the viability of this program in reducing health costs (mental and physical), education and justice system costs.

estimated by comparing the total costs of G.T. with the potential benefit of, for example, reduced health care needs. **FUNDING BEING SOUGHT TO HIRE A CONSULTANT**	• consider long-term outcomes for children and the services they have used and have not required.	

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In keeping with recommended approaches to program evaluation (see Scheirer, Shediac & Cassady, 1995; Pietrzak, Ramler, Renner, Ford & Gilbert, 1990) lower levels of evaluation research (i.e., process evaluation) have been used to inform subsequent levels of evaluation (i.e., short-term evaluation). No matter where one starts in the chain of evaluation, one must ultimately deal with the program as a whole (Pietrzak et al., 1990). Combined, the four levels of evaluation help to clarify areas for program development, critical components for the purpose of program replication, and the overall efficacy of the program.

The Process and Short-Term Impact Evaluation studies were designed to facilitate program planning and development and address questions related to the immediate effect of the program on parents and young children. Based on information collected in these two studies, a preliminary examination of the critical components of this community-based program is provided in *The Short-Term Impact Evaluation Study Report*. The Reports represent a beginning point in our enquiry into the efficacy of the Growing Together program.

1.4 Organization of the Report

This report is organized into nine chapters. The Introduction Chapter outlines the study purpose and provides a brief review of the relevant literature. In Chapter II the study's design is described along with an account of how the Program Logic Model was developed for the study. The Growing Together Logic Model provides a schematic representation of the program and identifies eleven program component areas. Procedures used in the development of study questions and data collection methods pertaining to each component area are detailed in Chapter II.

Findings appear in Chapters III through VIII. The eleven program component areas, (identified in the Program Logic Model), have been grouped into five major programmatic themes for discussion.

Chapter III provides a brief overview of the *Growing Together Team Partnership* between the *Hincks-Dellcrest Centre* and the *Toronto Public Health Department.*

Chapter IV, *Early Contact with New Mothers and Infant Assessment,* addresses those program activities involved in the contact/intake and assessment/ tracking aspects of the program.

Considered in Chapter V, *Prevention, Early Intervention and Health Promotion Initiatives,* are the activities of education, support and advocacy, and counselling and therapy.

Case management, referral and consultation, team development, and supervision and training, are

discussed in Chapter VI which is entitled *Team Management and Development*.

Community development and program promotion activities and Growing Together's Management Information System and research initiatives are discussed in Chapters VII and VIII respectively.

In Chapter IX findings of the Process Evaluation study are summarized and programmatic recommendations are made.

This report uses a double-column format. Text appearing in the inside column describes the findings of the study. References from the literature, tables, and figures, as well as the comments of interviewees and photos appear in the outside column.

II Design of the Study

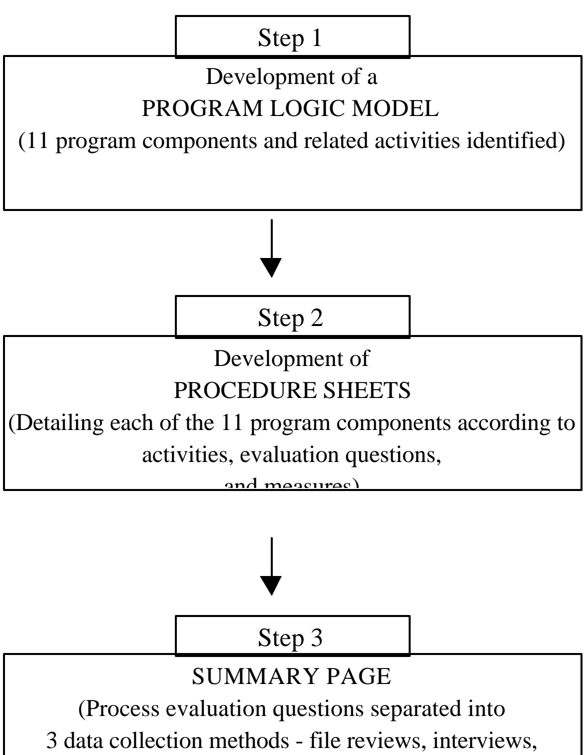
2.1 The Growing Together Process Evaluation Program Logic Model

Between September and December of 1996, members of the G.T. research team outlined a framework from which to proceed. Illustrated in Figure 2 are the three steps taken in designing a procedure and method for the Process Evaluation study.

The first step required the development of a Growing Together Program Logic Model. The Model provided a schematic representation of the program and helped in the identification and organization of key questions needing to be addressed.

In developing the Program Logic Model, the research team began by identifying Growing Together's major program component areas. Eleven program components were noted: Contact/Intake; Assessment; Referral and Consultation; Community Development and Program Promotion; Case Management; Counselling/Therapy; Support and Advocacy; Education; Team Development; Training and Supervision; Information Management and Research; Partnership and Team Networking.

Figure 2
Process Evaluation Design Procedure



Logic models

Health professionals have increasingly become interested in the use of logic models to facilitate program evaluation. ... Early work by Suchman highlighted the importance of organising short- and long-term goals, as well as the underlying assumptions of a program, as a hierarchy of objectives… Particularly in the formative stages of a program, the analysis of program outputs provides evidence of progress toward the achievement of the short-/ long-term outcomes, and permits mid-course adjustments.
Moyer, Verhousek, & Wilson, 1997, p. 96 - 98

Table 3
Example Procedure Sheet

Program Component: Assessment (Objective: To assess children and parents throughout the 0 to 5 year period to allow for the early identification of difficulties).

Program Activities	Evaluation Questions	Data Collection Strategies
1. To assess health related problems by telephone immediately after birth and identify any difficulties, related to infants and mother's health.	1a. What risk issues do PHNs identify upon initial contact, and how do they respond? 1b. How often is breast feeding an issue of discussion for the PHN? What other issues arise, what form of intervention?	1a/b. DPH file review for problems addressed at time of initial telephone contact.

Next, attention was directed toward naming the activities taking place within each program component area. Program activities as detailed in the Program Logic Model describe the program as it should be operating. Upon its completion, the appropriateness and comprehensiveness of the Program Logic Model was confirmed with two Growing Together staff members. The program activities identified in the development of the Program Logic Model appear on the opposite page in Table 2.

The second step called for the development of detailed procedure sheets for each of the 11 program component areas. Appropriate evaluation questions related to each of the program activities were proposed. Following this, data collection methods for each question were identified. The format of the procedure sheet appears in Table 3 and demonstrates how an identified program activity informed question formation and data collection methods. Procedure sheets appear next to each component area in the findings chapters that follow. The figures provide a summary of the activities, questions, and measures used in studying each of the program areas.

In the final step, summary pages were developed for each of the three data collection approaches (file reviews, interviews, review of the Management Information System). Interview summary sheets, for example, offered a complete list of the questions to be addressed as well as the people to be interviewed (i.e., workers, clients, outside service provider.) These pages helped organize the data collection phase.

Table 2. The Growing Together Program Logic Model: Program Activities

PROGRAM COMPONENTS:	1. Contact / Intake	2. Assessment	3. Referral and Consultation	4. Community Development & Program Promotion	5. Case Management
PROGRAM ACTIVITIES	1. . To reach out to families with young children living in St. Jamestown and encourage their program participation. 2. To contact all new mothers by telephone and complete initial information sheets. 3. To re-contact those families who agree to a second phone call from a G.T. intake worker. 4. To obtain background information on all G.T. clients.	1. To assess health related problems by telephone immediately after birth and identify any difficulties related to infant and mother health. 2. To complete a Risk Factor Assessment (RFA) with all families of new babies, who agree to the G.T. program, as soon after birth as possible. 3. To determine the risk and protective factors of a family and assess each family as low, moderate or high risk. 4. To assess and track children for developmental delays or problems, through the Infant Monitoring System. 5. To have parents visit the Developmental Clinic as soon as possible after the birth of their child and to complete a developmental assessment with any referred children. 6. To monitor and track children's developmental progress through the Developmental Clinic during the first five years of life	1. To refer G.T. clients to appropriate outside services as well as encourage referrals to the program. 2. To facilitate the internal referral of clients identified as having additional needs. 3. To consult with other community agencies or groups working with parents and provide clients consultation concerning developmental behavioural and parenting issues, as well as educational training.	1. To encourage a sense of belonging among St. Jamestown families of young children. 2. To facilitate the community organizing and mobilizing for local and Government change. 3. To teach parents new skills and approaches to their lives and to encourage them to utilize current capacities. 4. To support entrepreneurial activities of mothers in St. Jamestown (i.e., catering business, cookbook, cooperative day care, computer skills class).	1. To review, in team meetings, families in which RFA has been completed and to evaluate degree of risk, need, and appropriate response. 2. To open a case file for all families being followed, provide a formulation of each case and conduct bi-annual clinical case reviews. 3. To conduct clinical case consultation as a multi-disciplinary team on a weekly basis.

PROGRAM	Prevention / Early Intervention			9. Team Development,	10. Partnership	11. Management Information System
COMPONENTS:	6. Counselling & Therapy	7. Supportive & Advocacy	8. Parent Education	Training, & Supervision		/ Research

PROGRAM ACTIVITIES				
	1. To offer parents of young children, identified as moderate and high risk, opportunity to develop a caring relationship with a G.T. worker(s), and to promote healthy relationships within and outside of the family and offer opportunity to resolve parenting issues resulting from unresolved trauma, abuse and loss during their early lives. 2. To provide psychiatric assessment, counselling and medication for parents who display symptoms of depression or psychosis. 3. To provide crisis intervention when needed. 4. To provide infant/child focused interventions which encourage optimal physical, cognitive and emotional development.	1. To address the fundamental life needs of families (housing / nutritional and childcare needs). 2. To promote a stimulating childcare environment and allow children to meet other children. 3. To encourage parents to attend groups and activities to meet other people in the community.	1. To promote with mothers the benefits of breast feeding and healthy nutritional practice during pregnancy and after on an individual or group basis. 2. To promote and support good parenting skills by educating parents about child development, bonding and attachment issues, and life style.	1. T su th m hi ar cc in 2. Tc or tr: su / s vc w ag bu er te te in ot th 3. Tc fc ar ap vc G ne 4. Tc ar le ak cc ba in pr of or su st

2.2 Data Collection Approaches

Three data collection methods were relied upon for the Process Evaluation study: file reviews, interviews, and review of the existing Growing Together Management Information System (MIS). Quantitative and qualitative data collection methods were combined. File review and Management Information System data, for example, were quantified. The qualitative method of semi-structured interviews, on the other hand, was useful for collecting more open ended, descriptive data about the insights and experiences of staff, students, volunteers, outside agency personnel, and clients. Data collection approaches are further described below and are summarized in Table 4.

2.2.1 File reviews

Case file reviews were conducted at Growing Together (Developmental Clinic files), the Hincks-Dellcrest Centre (G.T. clinical files), and at the Public Health Department (Public Health Nurse files). To make the task more manageable, the examination considered program operation over a one year period (i.e., between January 1996 and December 1996). Data abstraction protocols were developed for each file review according to the specified evaluation questions of the Program Logic Model. Protocols were pilot tested on 5 to 10 files and modified as required.

Between June and August of 1997, a full review of all files discharged during the year 1996 was conducted at the Toronto Public Health Department. A total of 359 files were reviewed.

Cases discharged in 1996 were reviewed rather than cases opened since D.P.H management organized its file accounting system in this manner. The majority of cases seen by D.P.H staff, however, are opened and closed within the same year, with very few cases being followed longer than a one year period.

During the month of November 1997, 90 Developmental Clinic files, which were opened in 1996, were reviewed. Finally, 78 clinical files opened by G.T. staff in 1996 were reviewed in February of 1998. A total of 527 case files were reviewed for the study.

2.2.2 Interviews

Fifteen Growing Together staff took part in one-to-one semi-structured interviews about operational and procedural issues related to the 11 program component areas (See Figure 3 for sample questions). Staff were also asked to discuss those program components which they considered to be critical to program success and replication. Hincks-Dellcrest Centre and D.P.H staff completed virtually parallel interview protocols. Questions referring to areas in which the interviewee was not involved, for example community development activities, were simply skipped over.

Specialized interview protocols were developed for people at Growing Together with specific roles within the program. The program's childcare coordinator and intake worker took part in semi-structured interviews which focused primarily on

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1a. Have
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1b. (*If yes*
have
were
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1c. Have
done

() 1.
() 2.
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1d. What
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their specialized tasks. The office secretary completed a brief questionnaire.

Twelve current or previous students and volunteers were interviewed about their placement experiences at Growing Together. Ten clients were also interviewed about their involvement with the Growing Together program and, in particular, were asked to comment on their level of satisfaction with the manner in which services were delivered (See Figure 4 for sample items). Finally, six outside service personnel representing community organizations with which program staff have had ongoing contact, were interviewed about their perception of the Growing Together program in general and its impact on the St. Jamestown community.

2.2.3 Review of the management information system

The Process Evaluation study offered opportunity to examine the data accumulated within the Management Information System at G.T. (e.g., Risk Factor Assessment data, Developmental Clinic data) (See Table 4). In addition to being an important source of information about the operation of certain program areas, use of the System allowed for the assessment of its completeness. As a result, the data collection procedures of the G.T. Management Information System were enhanced.

2.3 Data Analysis

Service delivery within the Growing Together Program was investigated through file reviews and the examination of the existing Management Information System. Analysis of these data has involved the use of descriptive statistics, such as frequency distributions, means, percentages, and cross tabulations.

The inclusion of qualitative data in the Process Evaluation Study provided further clarification about the program's operation. Analysis of the open-ended data was guided by the structured nature of the interviews themselves. Constructed with specific questions in mind, analysis of the interviews was informed by these pre-conceived areas of interest. Standardized questions about each of the 11 program component areas, for example, ensured that respondents were consistent and that their comments were easy to interpret. While answers varied according to the various experiences of workers, emerging themes and patterns were quickly identified simply by reading over the elicited quotes.

III The Growing Together Team

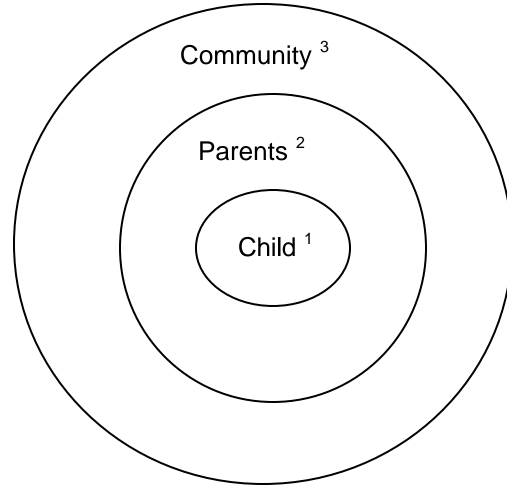
3.1 Team Partnership

A collaborative partnership between the Hincks-Dellcrest Centre and the Toronto Public Health Department is crucial for the effective operation of this community-based program. Outlined in Table 5 are the program activities, questions, and data collection techniques used in studying the program component area of *Team Partnership*. Two partnership activities are discussed in this Chapter: 1) the formation of a cohesive multidisciplinary Growing Together team; and, 2) the facilitation of a multidisciplinary practice among team members.

Table 5
Procedure Sheet: Partnership Component

Program Activities	Evaluation Question	Data Collection Strategies
1. To draw on the expertise of a diverse and varied group of professionals.	1. What is the staff make-up at Growing Together, how much time are people able to allocate exclusively to G.T. work, and how are workers paid for their time?	1. Interviews with staff about their backgrounds, time, and payment.
2. To provide opportunity for Public Health and Hincks staff to effectively collaborate and develop multidisciplinary skills.	2. What do team members learn about the work and perspectives of other professions represented on the team? How often is a case referred for expertise of other team members? How multidisciplinary are team members?	2. Interview staff about their experience of learning from other disciplines on the team.

Figure 5
Services of the Growing Together Program



[1] Child Services
Developmental Clinic
Infant Monitoring System
TLC[3] Initiative
Preschool Program
Saturday Afternoon Group
Play Therapy
Toy Lending Library
Consultation
Parent-Infant

[2] Parent Services
In-home Visits
Counselling
Parenting Groups
Skills Development
Support Groups
Therapeutic Groups
Interactional Coaching
Consultation

[3] Community Services
Community Kitchen
Safety Committee
Art Show
Community Garden
Initiative Against Family Violence
Special Events (i.e. Christmas Party)

Team Partnership Activity #1: To draw on the skills and expertise of a diverse group of professionals.

Professionals from various backgrounds make up the Growing Together team. Staff possess a range of skills which include leading groups, conducting in-home visits, providing counselling and psychotherapy, assisting with meeting the basic needs of families, working in the Developmental Clinic, and facilitating community collaboration. A schematic of the Growing Together program which appears in Figure 5, illustrates the vast array or program services directed toward the child, parent, and community.

Two co-directors head the project; one a Developmental Psychologist with the Hincks-Dellcrest Centre, the other a Public Health Nurse Manager with the Toronto Public Health Department. An Advisory Committee, representing a number of agency personnel and parents from the surrounding area, helps to oversee the project.

Six Infant Mental Health Workers are part of the team. They include, three psychologists, a social worker, a psychiatrist, and a Tamil speaking community home visitor. Most are employed on a part-time basis, with only two workers being full-time and the remainder working one to two days per week. Also affiliated with the project are six Public Health Nurses from the Toronto Public Health Department. Their hours with the project range from one to three days a week. Time spent varies depending on whether groups run by the Nurses are operating at the time, whether a nurse is

a member of the Developmental Clinic team and the number of clients requiring home visits.

Developmental Clinic staff include two public health nurses, as well as a developmental psychologist who is available two days a week, and a paediatrician who is on site at the Clinic two hours a week.

In addition to these project personnel, a Community Home Visitor/Advocacy Worker is employed on a full-time basis, as is a project Secretary. Employed four days a week are a Community Development Worker as well as a Research Coordinator who monitors the program's Management Information System.

The capacity of the team is further enhanced by links with the University of Toronto, York University, Ryerson Polytechnic University, George Brown College, and Seneca College. At any given time, two to six undergraduate and post-graduate students are on placement at the project to receive training in prevention and early intervention strategies. Students typically remain with the project 3 to 8 months.

Generally, there are seven to ten individuals volunteering with the program, whose skills, commitment, and responsibilities differ from person to person. Volunteers may run skill enhancement groups, work in the childcare room, or assist project staff. The Coordinator of Child Care services, at the Growing Together project, was a Volunteer for over three years after which she joined the TLC[3] project on a part-time basis as Coordinator of the Preschool Program. A new

addition to the program, the TLC[3] Project, provides parents with the services of a Speech Pathologist one day a week, a full-time Resource Consultant, and a Tamil Home-Visitor worker one day a week.

It is difficult for staff to meet the needs of high risk families given the part-time nature of many positions. Moreover, staffing hours fluctuate. Project staff, not affiliated with the Public Health Department, are supported by multiple funding sources on a short-term, contractual basis. Stress related to contract renewal and job loss has been exceedingly high over the years. Recently, as of April 1998, hours were reduced for a number of full-time and part-time personnel. Many have been with the project since its inception or shortly thereafter. Commitment to the project is considerable enough for some employees to have continued in their jobs for short periods of time while awaiting contract renewal and/or funds for payment of salary.

The uncertain nature of short-term funding, the quick turn over rate of students on placement, and the limited time commitment of some volunteers, can result in a lack of continuity for those working with the program, as well as for those parents receiving services. Regardless of these constraints, the high calibre of training, professionalism, and commitment demonstrated by Growing Together team members is appreciated by both those within the program as well as by social service professionals in the surrounding community. Outside community services providers who were interviewed for the study commented on the impressive ability of the project to appropriately

Community professionals consider the program's team a critical component for success

It sounds corny, but they [the workers at Growing Together] are caring [about the people they work with]. Yet, I know that it's a very sophisticated program. Everyone is very well educated, but they get their message across clearly and simply and in a way that can be used. ... Many of the families are very happy that people from Growing Together come into their homes. ... The families speak very nicely of the workers there. ... you cannot tell the difference between the paid and volunteer staff, there's the same degree of commitment.
Local Community Service Professional

It's good to have different service providers with backgrounds like the [people who live in the] community.
Local Community Service Professional

I think there is a real effort [on the part of Growing Together workers] to connect with the clients and to be open to them and get them involved in whatever program is appropriate. I have had good communication with those working with the families [I have referred]. Staff will come to the [client's] home, to our meetings, [or] come to the day care.

meet the needs of multigenerational, high-risk families as well as those from various cultural groups. Predominant cultural groups, (i.e., Tamil, Pakistani, Filipino, Somali), are represented by team members who speak a variety of languages and are sensitive to relevant cultural issues. When needed, services are purchased from Access Alliance, an interpreter service in Toronto and AT&T Language Line Services.

The differing roles of staff, students, and volunteers are generally not apparent to outside service providers who consult with the project. Some students and volunteers mentioned this experience as key to their sense of being an integral part of the team, and contributed, in general, to their feeling supported and appreciated in their various roles.

The Growing Together team creates a feeling of support

[My experience at G.T. has] been good because of the team. I have never met a team like what we have here. ... I feel the support is a critical issue. ...It is mainly the team that has been the reason why I have wanted to continue [with the program].
Growing Together Worker

It's been incredibly rewarding [to be at Growing Together]. I feel really lucky to be here and like I have found my niche. I feel very supported here.
Growing Together Volunteer

It is pleasant to me that there is not a distinction between volunteers and staff [at Growing Together]. I enjoy the relationship between the volunteers and staff. It is particularly satisfying to have professionals to turn to when I sense a problem [with someone I am seeing in my group].
Growing Together Volunteer

Clients feel extremely satisfied with Growing Together Services

It is good to attend things here. For one thing it is good for my kids to associate with other kids and learn to co-operate. And for me, it is good to learn things. Just talking about your personal [issues] or about the needs in the community, like the drug dealing, is helpful. And with the parents' groups , you find solutions to your [parenting] problems. ...[My kids] are happy to come here [to Growing Together]. They find this place familiar and comfortable. They go directly to the playroom and look for the workers they know.
44 year old, Filipino Mother of 3 & 6 year old.

[I am extremely satisfied with Growing Together services] because [my G.T. worker] gave me a lot of information and helped me. [Also, in the] Prenatal Group they give a lot of information about breast feeding, cooking baby food, and eating healthy.
29 year old, Eritrian Mother of 22 month old.

I have learned a lot [at G.T.]. Especially about my birthing in Canada, ways to child rear, and child safety. I made a lot of friends here, and I feel welcome here. I [have] come to know more services. ... My son had an emergency with his tooth. From there I met the dentist, he told me to go to Public Health [and] find out about dental care. From there I came to know about Growing Together. I am really thankful [he told me about it].
41 year old,Filipino Mother of 6 month & 8 year old.

I come to [a parenting] class to learn more about being a mother. Growing Together is a good service to meet people [and] , make friends in the community. I like the people who work here , they are friendly and helpful.
29 year old, Tamil Mother of 16 month old.

Everytime I asked for help from them [GT workers], I get it right away. They never say no, they always help me right away ... Even if they are busy they always find time to do it [call me] as soon as possible.
39 year old, Filipino Mother of 2 and 6 year olds.

I am very satisfied with the services] because they [the workers] are always giving me information, it always motivates me to help out [at GT], and get out of the house.
43 year old, Canadian Mother of 3, 8 and 20 year olds.

Clients rated their overall satisfaction with the program, very highly (between 8 and 10: 1=not satisfied, 10=extremely satisfied). The majority expressed positive sentiments about staff friendliness, helpfulness, and availability. Interviewed mothers were impressed with the quality of the information they received both from group leaders and individual workers. Women also noted that the Growing Together site provided them with a place to go when they wanted to get out of the house and meet other community members.

3.2 <u>Team Partnership Activity #2</u>: To provide opportunity for Public Health and Hincks-Dellcrest staff to effectively collaborate, and develop multidisciplinary skills.

Growing Together team members are from the fields of social work, early childhood education, public health, medicine, psychology, and psychiatry. All interviewed staff felt their knowledge of other professions had expanded as a result of being on this multidisciplinary team. Team members learned about the work issues, tasks, and perspectives of those from other professions. Both PHNs and Mental Health Workers felt well informed about the skills and roles of the other. PHNs had opportunity to learn from the Infant Mental Health Workers on the team about the emotional development of infants/children and the mental health problems of children and adults. Mental Health Workers, on the other hand, gained insight into medical and health issues, including breast feeding and nutrition by consulting with PHNs. Infant Mental Health workers were consulted in relation to issues of abuse, parent-child relationships, family mental health, and developmental delays. The project's Psychiatrist provides staff with consultation and important information about diagnosis and the effects of various medications. The pediatrician provides in-depth medical consultation on special conditions of infants and pre-schoolers.

Overall, team members felt better informed about the difficult task of family advocacy work. Questions about immigration, community services,

Growing Together team members learn from each other

Certainly, I have learned with regard to the PHNs [about] the kinds of issues that they come into contact with. I have learned a lot more about breast feeding and health related issues and procedures than what I knew before [joining the team]. I have [also] learned more about medication and psychiatric disorders, and about advocacy work [such as how to get] FBA, and legal assistance.

I knew nothing about CD [community development] before. I had seen it as adversarial to clinical work. Now I see them [CD and clinical work] as working together and supporting each other.

[By being on the team] your assessment skills become better because you learn to recognize behaviour patterns in the parents and children. ... Seeing [the developmental psychologist] do assessments broadens your perspective of what is involved and [helps you to] concretely see what a child is capable of. It is something we are not exposed to [as PHNs] and working with these people [G.T. team members] gives you a chance to see it first hand.

day care subsidies, and housing were commonly addressed by the Advocacy Worker. As well, the positive role played by community development in an Early Intervention Project was made clearer to team members because of the efforts of the Community Development Worker in facilitating community networking.

Growing Together workers also said they called upon the insider knowledge of staff who were also members of the local ethnic communities. For example, the program's Tamil Home Visitor was often approached by staff with questions about traditional birthing, nutritional, and social practices.

Team members respect and rely upon the skills and expertise of one another. Communication about topics of interest and case consultation frequently occurs, resulting in significant learning and the development of a multidisciplinary team.

3.2 Summary

The collaborative partnership between public health and a children's mental health centre, along with the multidisciplinary nature of the Growing Together team, has enhanced the quality of service delivery and team support. The Growing Together team represents a variety of professional disciplines, community home visitors, students and volunteers. The breadth of training and experience shared by team members ranges from expertise with child development, advocacy, parenting, health promotion, medical and psychiatric interventions, community development, cultural sensitivity, early childhood education, and clinical strategies. This

wide range of knowledge is important in order to be able to meet the needs of families who live in the St. Jamestown area. Training and expertise are important along with the willingness to share information and to learn from each other. Openness to a variety of intervention approaches has enriched the range of services available to the community.

The support the team provides to each other and the respect given to all team members has maintained a high level of morale, enabling staff to meet the intense and often overwhelming needs of children and their families. At the same time, the continual uncertainty about job security has made it difficult to maintain commitment and services at a consistent level. Piecemeal funding which comes and goes, along with expectations for evaluation which it often brings with it, has placed additional stress on the operation of the program. Future efforts need to prioritize the stabilization of funding so staff can have longer-term contracts and the same level of employee benefits as other staff at their respective agencies. Without this it will be extremely difficult to maintain the high level of caring, commitment, responsibility, and quality of service which is critical to clients and other service providers in this community.

IV Early Contact With New Mothers and Infant Assessment

Early contact with all new mothers living in St. Jamestown and the assessment and tracking of their infants' development are key priorities of the Growing Together program. Examined in this chapter are the program areas of client *Contact and Intake* and the *Assessment and Tracking* of infants and their families.

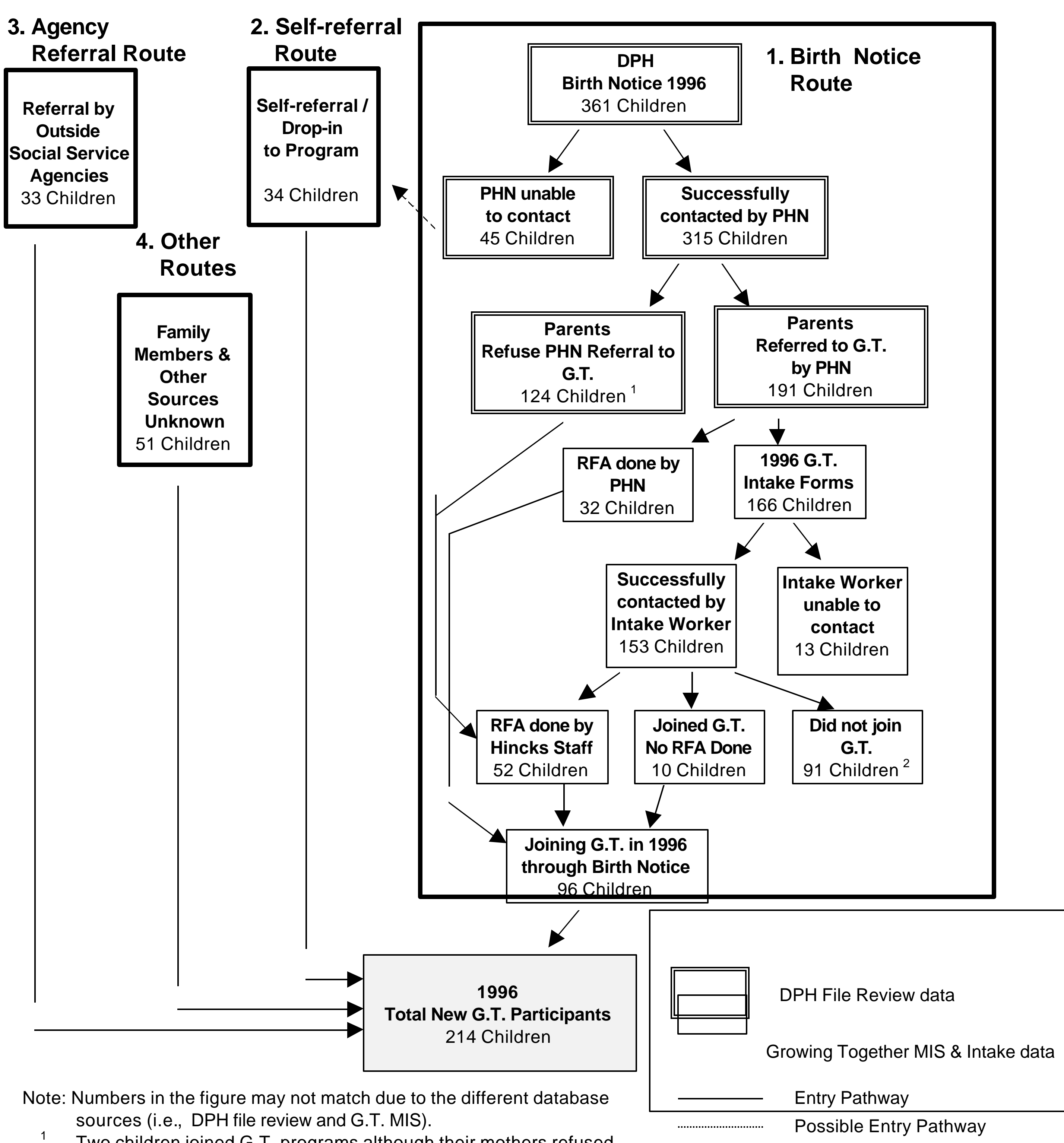
4.1 Contact and Intake

The overall objective of the program's *Contact and Intake* initiative is to reach and offer services to all families living in St. Jamestown who have children between birth and 5 years of age. The procedure sheet seen in Table 6, summarizes the activities, questions, and data collection methods used to examine the operation of this program component area. Four program activities are identified and addressed under this component heading: 1) reaching out to all families with young children in St. Jamestown and encouraging program participation; 2) contacting and conducting initial health interviews with new mothers by telephone; 3) re-contacting parents who agree to the Growing Together program; and 4) obtaining intake, or background information, and assessing the needs of Growing Together families

Table 6
Procedure Sheet:
Contact/ Intake Component

Program Activities	Evaluation Questions	Data Collection Strategies
1. To reach out to families with young children living in St. Jamestown and encourage their program participation.	1a. What are the various routes of entry into the program,? What are the characteristics of clients entering through means besides birth notices?	1a. Interviews with G.T. and DPH staff to determine routes of client entry. Review MIS data for characteristics of those clients who enter other ways besides through birth notices.
2. To contact all new mothers by telephone and complete initial information sheets.	2a. What proportion of new births are successfully contacted by telephone by PHN? What are the reasons for no-contact?.	2a. DPH file review. Data from birth notices on those new mothers contacted, proportion not contacted and reasons for no-contact.
3. To re-contact those families who agree to a second phone call from a G.T. intake worker.	3a. How many of those contacted by PHN agree to a follow-up by a G.T. intake worker. How many of the clients contacted by G.T. intake worker agree to follow-up? 3b. How do the characteristics of families who agree to G.T. services compare with those who refuse?	3a. G.T. MIS Intake Database on number of referred families, number contacted and accessed. 3b. Interviews with G.T. intake worker to explore barriers to access and loss of families at intake stage.
4. To obtain background information on all G.T. clients.	4a. Has background information been collected on all G.T. clients, including those who attend groups, clinics, receive home visits? What background information is collected on clients referred by	4a. Review of existing intake forms and MIS records on G.T. clients . 4b. Interview G.T. staff about their intake reporting procedures (i.e., is background information. on group members always collected, differences between Hincks and DPH policy).

Figure 6
Four Paths of Client Entry to the Growing Together Program



Note: Numbers in the figure may not match due to the different database sources (i.e., DPH file review and G.T. MIS).

[1] Two children joined G.T. programs although their mothers refused the referral & risk assessment initially at birth.

[2] Eight children from this group joined G.T. through self-referral or other unknown sources. Another 7 children joined G.T. later in

<u>Contact/Intake Activity #1</u>: To reach out to families with young children living in St. Jamestown and encourage their program participation.

In 1996 a total of 543 young children from 477 families participated in the Growing Together program. Within this group were 214 children and their families who were new to the program. Clients learned about and entered the Growing Together program in one of four ways: 1) through DPH Birth Registration Notices (BRNs) and PHN contact, 2) by way of an outside agency referral, 3) by self-referral, and 4) through various other means (e.g. family members already in the program).

Paths of client entry into the program are demonstrated in Figure 6. Depicted are the various ways clients join the program, and the total number of participants who successfully join according to each of the four contact/intake approaches[2]. The following discussion provides an overview of the program's four client contact and intake methods.

The first and most successful method for reaching and encouraging the participation of parents in the program, involves the use of the Public Health Department's Birth Registration Notices (BRNs). Birth Registration Notices are completed by hospital staff whenever a child is born. Nurse's working with the Growing Together project contact

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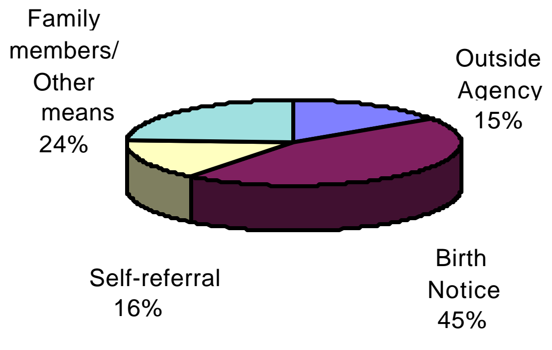
[2] The totals depicted in Figure 6 are from two different databases (DPH file review and the Growing Together Management Information System). This is indicated in Figure 6 with double boxes demarking the DPH file review data and the remainder indicating the Management Information System data. Because of these different data sources and methods for calculating a one year period, the numbers presented do not match exactly across these data sets.

new mothers living in the St. Jamestown community by telephone on the basis of this information.

Parents may join the program immediately by agreeing to the program while receiving visits from a Public Health Nurse. In this case, a Risk Factor Assessment would be completed by the nurse. As seen in Figure 6, 32 Risk Factor Assessments were completed by PHNs in the year 1996. Parents may also agree to be referred to the Growing Together program in order to further discuss the services provided. One-hundred and sixty-six parents were referred by the PHNs to a Growing Together Intake Worker in 1996. These mothers had expressed an interest in learning more about the program at the time of initial PHN telephone contact. In 1996, 153 mothers were successfully contacted and informed briefly about the program. Subsequently, a total of 62 families joined the program either by having a home visit and completing a Risk Factor Assessment interview (n=52), or by entering the program directly (n=10), for example, by joining a group.

Figure 7
Source of Referrals (N=214)



Overall, the Birth Registration Notice contact/intake procedure was responsible for directly facilitating the joining of 45% of Growing Together clients in the year 1996 (see Figure 7).

In addition to this path of entry, parents in the community come to the Growing Together site on their own. Self-referral to the program accounted for 16% of those clients who join in a year (see Figure 7). Parents hear about the program from other community agency workers or other parents. Many of those who refer themselves to the program

)
%
24
32
30
11
2

to 100 due

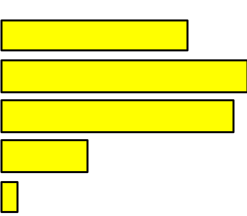
are likely to have been contacted previously by a Growing Together PHN or by the Intake Worker.

Referral of parents with young children to the Growing Together program by outside agency providers is the third most frequent route of entry, accounting for 15% of those joining (see Figure 7). Parents were referred to the Growing Together program by: the local Children's Aid Societies, Central Neighbourhood House, Hincks-Dellcrest Centre, the local English as a Second Language program, non-affiliated PHNs, the Rose Avenue Parenting Centre, the Salvation Army, Victoria Day Care Centre, and by local physicians. Growing Together staff have networked with these local service providers in order to increase their awareness of the program. (Program promotion is further discussed in Chapter VII).

Those families referred through community services were more likely to be identified as being at high risk for detrimental child outcomes. In particular, clients referred by the Children's Aid Society are often the most at risk.

The remaining proportion of those joining the program (24%) entered through other means. About two-thirds of these cases had family members who were already involved with the program. Remaining clients entered the program in ways that were not traceable through the Growing Together Management Information System.

***Contact/Intake Activity #2*: To contact all new mothers in the St. Jamestown community by telephone and complete intake information sheets.**



Public Health Nurses working with the Growing Together project are the first line of contact with new mothers living in St. Jamestown. Upon receiving the Birth Registration Notice (BRN) form at the Toronto Public Health Department (DPH), cases within the Growing Together (G.T.) census tract are flagged and assigned to nurses affiliated with the project.

In an effort to clearly understand the contact/intake procedures of Public Health Nurses, a DPH file review was conducted. A total of 359 Toronto Public Health Department file records were reviewed during the summer of 1997. Files proved to be a valuable source of background information on mothers and their infants[3]. Summarized in Figures 8 to 11 are the background characteristics of these mothers and their babies[4].

Figure 9
Ethnicity of Mothers (N=248)

Source: DPH File Review
Note: Total percentage does not add up to 100 due to rounding.

The majority of the mothers were 25 years of age or older (86%). Only 2% (n=8) were teenage mothers (see Figure 8). Ninety percent of the women were married and fewer than 10% were single. Mothers' ethnicity was not recorded for approximately one-third of the cases (n=114). In those cases where ethnic background was documented, Tamil and Filipino made up over one-half of the cases. Only 5% of the women were noted as being of Canadian descent (see Figure 9).

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[3] 362 infants were born during the one year review period. This number included 3 sets of twins and 2 still birth babies.

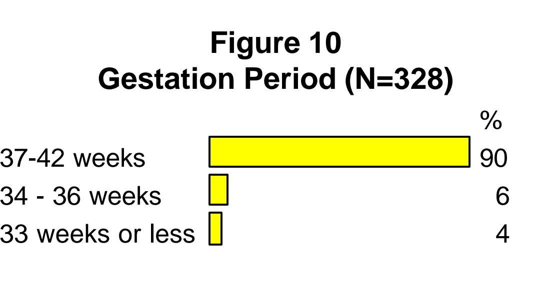
[4] The numbers cited in sections discussing the Birth Registration Notice Data (DPH File Review) reflect statistics on all mothers giving birth in St. Jamestown, and are not necessarily reflective of G.T client statistics.

Ethnicity may not have been recorded in cases where the client was of Canadian descent. While many of the women were not born in Canada, the majority (81%) of the 292 women, for whom data on language spoken was available, were able to communicate in English. Only 19% of the women were noted in the DPH file records as not being able to communicate in English at all.

Background information about father's age, ethnicity, and language spoken was missing from BRN information approximately 80% of the time. Consequently, it is not possible to discuss with any accuracy the background characteristics of these men.

Information about the infants themselves was more reliably present. There were slightly fewer first born infants (49%) with just over half being later born. Premature births (less than 33 weeks term) occurred in 4% of the St. Jamestown area cases (n=14). (This is higher than the Metro Toronto rate of 2% for the years 1990-95). Six percent of the St. Jamestown mothers (n=18) had pre-term births (34-36 weeks), and 90% carried their babies to full term (n=294) (see Figure 10). This rate is consistent with reports from the *National Longitudinal Survey of Children and Youth* (NLSCY) (1996).

Figure 10
Gestation Period (N=328)



Source: DPH File Review

National figures on premature births

Roughly 9.7% of children in the NLSCY sample were born prematurely (the survey considers a normal pregnancy to end between 259 and 293 days; those born before 259 days are called premature). The number of low birth weight babies was lower than the rate of prematurity: 5.7% of the infants aged 0 to 3 years surveyed had a low birth weight compared with 9.7% who were born prematurely. This figure is consistent with previous reports of the incidence of low birth weight, which has hovered around 6% for the last 20 years.
Human Resources Development Canada & Statistics Canada, 1996, p. 19.

Figure 11
Birth Weight (N=335)

	%
2500g or above	91
1501g - 2499g	7
1500g or less	2

Source: DPH File Review

Birth weight was low, (less than 2500 grams), in 9% of the St. Jamestown babies (n=30) (see Figure 11). This low birth weight figure, in comparison with that found in the *National Longitudinal Survey of Children and Youth* (NLSCY) (1996), demonstrates that the proportion of low birth weight children is higher in the St. Jamestown area than that for Canadian children (6%) born between 1991 and 1995. Statistics such as these verify the related risks to infants born to families living in St. Jamestown, a community, not unlike other high-risk neighbourhoods, where parents are struggling to overcome poverty, isolation, and health crises.

The Canadian average birth weight

Babies born at 2,500 grams (5.5 pounds) or more are of normal birth weight; those who weigh between 1,500 and 2499g at birth are of low birth weight; and those who weigh between 500 and 1,500g at birth are of very low birth weight. ... According to the NLSCY, almost 6.0% of the children in Canada born between 1991 and 1995 were of low or very low birth weight. Human Resources Development Canada & Statistics Canada, 1996, p.48-49.

In keeping with the goals of prevention and early intervention initiatives, a primary objective of the Growing Together project is to contact ***all*** new mothers residing in the neighbourhood in order to assess maternal and infant health and promote the Growing Together program. Review of the 1996 DPH records demonstrates that this objective is indeed being accomplished. In total, 87% of the 359 mothers (n=313)[5] (see Figure 4) were successfully contacted by telephone by a Growing Together Public Health Nurse (PHN). Of those successfully contacted, 48% (n= 140) received at least one additional telephone contact and 45% (n= 131) received at least one home visit from a PHN. Ninety percent of the nurses' initial visits took place before the infant was 14 days of age, with 90% of the cases being discharged by the time the infant was 2½ months old. Further discussion of PHN intervention patterns will be discussed under the component headings of *Assessment* and *Counselling/ Clinical Interventions*.

In contrast to these numbers, only a small proportion (n=45; 13%) of new mothers in the St. Jamestown area failed to be contacted by the PHNs. Reasons identified in the nursing notes for failed contact included: no one answering the telephone or responding to multiple messages; an out-of-service telephone; no telephone number being listed for the mother; and, an inability to locate the identified family physician. PHNs ensured a Birth Registration letter and Growing Together pamphlet were mailed to households in which parents were not reached by telephone.

[5] The number here refers to the number of mothers which does not match with numbers in Figure 6 which documents the number of children contacted.

There were no significant differences between the background characteristics of families who were successfully contacted by PHNs and those who were not. Mother's age, marital status, and infant's birth weight and gestation period were similar between these two groups. Fewer first born children, however, were part of the "no contact" group. This pattern may suggest that some parents who were not successfully contacted had fewer concerns due to their previously having had children.

***Contact/Intake Activity #3:* To re-contact families who agree to a second phone call from a Growing Together Intake Worker.**

PHNs promote those services available through the Growing Together program, in addition to providing St. Jamestown mothers with health counselling. A written referral form is completed by PHNs and given to the Growing Together Intake Worker once a mother agrees to the program. At this stage, the Intake Worker makes a brief telephone call in order to describe the program further and discuss whether the family would be interested in exploring which G.T. services would be most helpful.[6]

According to the 1996 DPH file review, 60% (n=189) of those successfully contacted by PHNs (N=313) agreed to a follow-up phone call from a Growing Together Intake Worker. One-hundred and twenty-four parents did not consent to having their name passed on to Growing Together program staff. In the majority of cases, women refused the Growing Together program because: there was no perceived need for the program; they were too busy, or were moving from the community. Characteristics of those who agreed to be contacted, in comparison with those who refused follow-up, were not significantly different.

While the prevention and early intervention initiatives of the Growing Together program were not received by the 124 parents who refused further

Initial contact from the Growing Together intake worker

I give them my name, [and say] I'm calling from Growing Together. I tell them that we work with parents and children in St. Jamestown and all our services are free. I mention that we have a Developmental Clinic where their children can be checked and we have a toy lending library where they can borrow toys, and groups they can attend to get together with other parents and discuss issues related to their children. I say there are a lot of different services, and its difficult to describe them all over the phone. We usually try to get together with them in person to see what of our services might be interesting to them and then ask them questions about themselves. ...I also check out how things are for them, but I am sensitive about not being too intrusive. I don't go too far. ... Then I ask them, "are you interested in having more information about the program?" Sometimes they hesitate at that point. [I] offer them a home visit if going out [of the house] is a concern [for them], but I also offer that they can come to Growing Together if they prefer. If they say yes to either option, I let them know someone on the team will be contacting them and I try to give them an idea about the amount of time they may wait [before being called]. If they say "no" [to meeting with someone from G.T.], I offer the mailing and recently I've also offered the Infant Monitoring System (IMS) at that point. If they say "yes" to the mailing I give their name to the secretary. If [they say] "yes" to the Infant Monitoring System, I pass it [their name] on to the IMS worker and she calls them back.

Growing Together Intake Worker

[6] Two Growing Together workers, one English the other Tamil speaking, conduct the telephone intake contacts. The referrals of clients who speak English results in contact being initiated by the Intake Worker. A Tamil speaking Community Home visitor calls clients for whom Tamil is the most comfortable language. For referrals of clients who speak another language, the Intake Worker occasionally asks a staff member who speaks the same language to make the call, or utilizes a translation service for that connection.

contact, there was substantial intervention from PHNs prior to case discharge. Of those who refused Growing Together services, 45% received two or more telephone contacts from the PHN and 37% received at least one home visit. Overall, almost one-half of the 124 families who refused Growing Together services received an initial assessment of infant and maternal health as well as any required interventions.

During the year 1996, the Growing Together Intake Worker was given 166 DPH referral forms for the Growing Together program[7]. Of the 166 DPH referred cases, 153 or 92% were successfully contacted by telephone: 39% requested an appointment (i.e., either a home visit or an appointment at the G.T. office); 29% asked for a mailing rather than a home visit; and 3% were already attending the program. Only 9% of the families indicated they were not interested in receiving further information.

Of the 153 clients contacted by the Growing Together Intake Worker in 1996, 62 (41%) joined the program.

[7] The number cited from the Growing Together Intake Worker statistics (N=166) will not match the cited number of PHN cases that were referred to G.T. according to the DPH file review (N=189). The method for determining a one year period differed between these two data pools and therefore these statistics, while falling within range of one another, vary slightly due to monthly fluctuation patterns in the number of births and successful contacts.

***Contact/Intake Activity #4*: To obtain background information on all Growing Together clients.**

A program's intake procedures are central to an effective clinical and client tracking mechanism. Intake data, collected at the time of a client's initial entry into the program, provides workers with basic background information about the families with whom they become involved. Additionally, background information is important for research purposes. Most notably, intake data, organized through a Management Information System, offers an overview of the characteristics of families that join the program over a given period of time. Furthermore, intake information provides an opportunity to effectively track clients through various aspects of the program. This second point is particularly important given the multidimensional approach of the program. For purposes of program development, it is important to understand the service use patterns of clients.

As described earlier, not all clients enter Growing Together in the same manner. While many clients enter through the Public Health Department's Birth Registration Notice route, others self-refer, while some are referred by community agencies. These various routes of entry into the program have made the implementation of standardized intake procedures challenging.

Attempts to standardize the intake reporting procedures at Growing Together were most recently attempted in September of 1997 with the completion of a Growing Together *Consent to Release of Information* form. The form serves as

a general consent to disclose information between the *Toronto Public Health Department* and the *Hincks-Dellcrest Centre*. It also provides background information about the client, and the services in which they intend to participate. The form is to be filled out and signed at the time of Risk Factor Assessment (RFA) completion, at the start of group participation, or when entering the Developmental Clinic. Interviewed staff lacked clarity on how and when this new form was to be completed.

Background information on Growing Together clients has to date been collected most thoroughly and consistently through the completion of the Risk Factor Assessment Interview (RFA). Both Public Health Nurses and Mental Health Workers conduct these interviews. Clients who complete the RFA generally enter through the Birth Registration Notice route or are referred by an outside agency. These clients are interviewed during home visits, and thereby provide workers with intake information. On the other hand, clients who self-refer to the program may not receive a home visit, and are therefore less likely to provide initial intake information to a worker.

Group participation of Growing Together clients, in particular, has been difficult for workers to consistently document and track. The general *Consent to Release Information* form was intended to facilitate the group leaders in their attempt to collect background information from participants. Unfortunately, the form has not been used consistently. Group leaders have typically provided some data about group participants for the purpose of updating the Management

Information System. Background information provided by group leaders has included: client's name, address, telephone number, child's name and date of birth, and number of siblings. Background information being entered into the Management Information System, however, varies from group to group, thus resulting in a less than complete database.

Most recently, the group leaders of a therapeutic group have included the completion of an RFA as part of their initial contact procedure. This approach is particularly important when clients are attending therapeutic groups and are at risk for emotionally reacting to the content. As a general approach, however, it would not be a viable procedural inclusion. Many groups, for example, are supportive and social rather than therapeutic. In these situations, group leaders often feel that asking clients to disclose extensive personal information is invasive and may result in the loss of parents from the program.

Barriers to gathering intake information at the program have included a variety of additional circumstances. First, there has been an on-going struggle to resolve inter-agency policy differences between the Hincks-Dellcrest Centre and DPH in relation to the issue of client confidentiality and information sharing. In the past, for example, PHNs collected information on their group participants and did not supply this information for inclusion in the Management Information System database. Clients attending Public Health Nurse groups were not considered to have consented to personal information being shared with the project.

The comfort level of workers with the questions being asked on the RFA has also played a role in the successful completion of intake information. Considerable perseverance may be required by workers attempting to complete intake information with clients who are at heightened crisis at the time of the initial visit. Workers may as well harbour a general apprehension about asking clients for personal information, such as questions about family income. Additionally, the existing intake referral form is perhaps too brief for documenting information on complex cases referred by outside agencies.

There is an overall need for basic demographic information to be consistently collected across all services of the program. Most notably missing pieces of information at intake have been: source of client referral, OHIP numbers, ethnicity and, family's socio-economic status.

4.2 Assessment and Tracking

Activities undertaken in the *Assessment and Tracking* component area are intended to facilitate the early identification of developmental delays and/or situational circumstances that may result in negative outcomes for children. Generally, two program initiatives contribute toward the accomplishment of this objective: first, the early assessment of risk and need within a family through early contact and administration of the Risk Factor Assessment (RFA) interview; second, readily available developmental assessments and the tracking of children during the birth to 5 year period.

Six *Assessment and Tracking* activities are examined here: 1) assessing infant/maternal health by telephone immediately after birth; 2) completion of a Risk Factor Assessment (RFA) with families who agree to the Growing Together program; 3) determining the degree of risk present in a family through the RFA; 4) developmentally assessing and tracking children through the Infant Monitoring System; 5) completing developmental assessments with all children referred to the Developmental Clinic; and, 6) monitoring and tracking children's developmental progress during the first five years of life through the Developmental Clinic. Table 7 outlines these six program activities, related questions, and data collection methods.

Table 7
Procedure Sheet:
Assessment Component

Program Activities	Evaluation Questions	Data Collection Strategies
1. To assess health related problems by telephone immediately after birth and identify any difficulties related to infant and mother health.	1a. What risk issues do PHNs identify upon initial contact, and how do they respond? 1b. How often is breast feeding an issue of discussion for the PHN?	1a/b. DPH file review for problems addressed at time of initial telephone contact.
2. To complete a Risk Factor Assessment (RFA) with all families of new babies who agree to the G.T. program, as soon after birth as possible.	2a. How many RFAs are completed yearly? What reasons are there for some failing to be completed? 2b. How old are infants when RFAs are completed? 2c. What are parent and staff's perceptions about the efficacy of home visits?	2a. Management Information System (MIS) 2b. MIS to determine age of infant at time of RFA visit . 2c. Interview G.T. staff to learn reasons for incomplete RFAs and perception about efficacy of home visits . Interview parents about home visiting.
3. To determine the risk and protective factors of a family and assess each family as low , moderate or high risk.	3a. What are the range of difficulties (in the parent, child, family and their interactions) identified through the risk factor assessment? 3b. What proportion of the G.T. population fall into the three risk categories?	3a/b. MIS to determine the range of risk factors and the proportion and characteristics of families in each of the three RFA risk categories
4. To assess and track children for developmental delays or problems, through the Infant Monitoring System.	4a. How many children are being tracked through the mail-out Infant Monitoring System ? 4b. How many children have been identified as having health and/or developmental difficulties through the IMS? What types of problems have been identified; what interventions prescribed, outcome? 4c. What are the characteristics of families referred to the Infant Monitoring System? Who referred them? How have clients received this approach?	4a. IMS data on computer file for number of packages sent out and received back. 4b. Review of IMS database for results and identified problems (Review developmental clinic file for follow-up with those identified as having problems). 4c. Interviews with IMS staff about types of families referred .
5. To have parents visit the Developmental Clinic as soon as possible after the birth of their child and to complete a developmental assessment with any referred children.	5a. How many developmental assessments are completed through the developmental clinic? Kinds of assessments, Outcome? 5b. How many parents visit with the clinic staff? How soon after birth? What types of issues are addressed during visits? How many appointments are kept/missed?	5a. MIS to determine how many DISCs etc. have been completed and outcome. 5a. MIS re. number of clients seen at the Developmental Clinic. 5b. Review of Developmental Clinic files to identify characteristics of families who come to the clinic, age of child at time of visit(s), issues addressed by doctor and PHN, outcomes?
6. To monitor and track children's developmental		6. MIS and Developmental Clinic file review of

Figure 12
Postnatal Summary –
Maternal Information

Figure 13
Postnatal Summary-
Infant Information

<u>Assessment Activity #1</u>: To assess health related problems by telephone immediately after birth and identify any difficulties related to infant and maternal health.

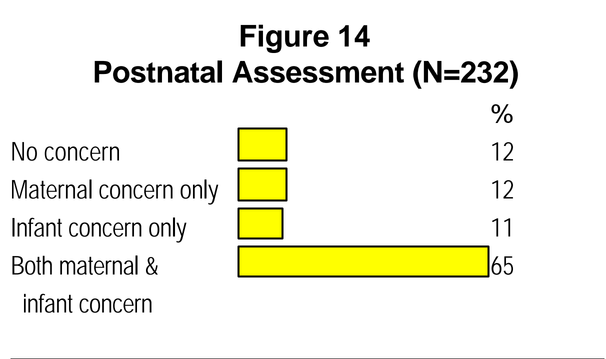
PHNs assessed the health status of 312 mothers and their infants who were living in St. Jamestown during the year 1996. On average, there were ten days between the time of a child's birth and the Public Health Nurse's initial telephone contact.

Nurses initially assess both maternal and infant health over the telephone. With the guidance of a Public Health Department postnatal sheet, health areas are addressed with both mother and child. For example, it is standard practice for PHNs to discuss and document women's breast care status and their infant's feeding patterns. (Postnatal summary sheets used by PHNs to document information about maternal and infant health appear opposite in Figures 12 & 13).

Postnatal sheets were not always successfully completed by PHNs as some mothers felt unable to take time to respond to questions. Eighty St. Jamestown mothers (26%) did not complete the questions during the year 1996. These women did, however, answer general questions about their own and their baby's health. Women who did not complete postnatal questions over the phone were significantly less likely to have recently given birth to their first child (25%) in comparison to those mothers who did take time to answer the questions (63%). Having previous children perhaps resulted in women feeling less anxious about health issues. Otherwise, there were no notable differences

between mothers who completed and did not complete postnatal questions.

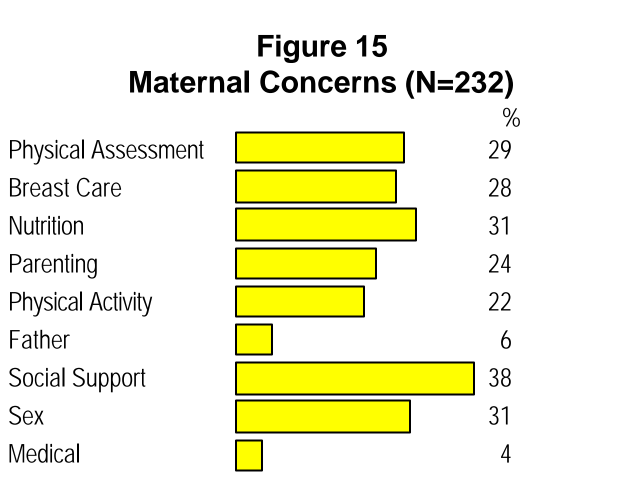
Although having had a previous child was likely to reduce some women's health worries, the majority of women contacted reported health concerns. Based on the 232 postnatal sheets completed in 1996 it was found that 88% (n=204) of families had at least one health concern. Two-thirds (65%) had both a maternal and infant health concern. The remainder had either a maternal (12%) or an infant health concern (11%) (see Figure 14).



Source: DPH File Review

In cases where health concerns were reported, home visits or telephone follow-up were offered, during which PHNs answered questions and provided support. On average, women received 3 telephone contacts and one home visit over the course of 27 days of service.

Common concerns identified by PHNs are summarized in Figures 15 and 16. Maternal health issues were dominated by: limited social support networks, nutritional needs, overall physical health, and breast care concerns such as cracked or sore nipples. Many women were isolated and had little social support outside of their husbands as they were new immigrants whose relatives were not living in Canada. Others were simply estranged from family members. These mothers were generally referred to the Growing Together program and the *When Baby Comes Home* group, operated by the Public Health Department Nurses.



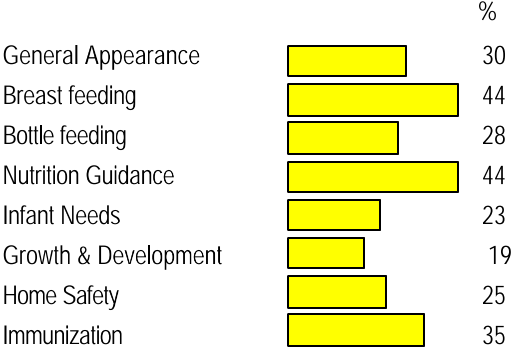
Source: DPH File Review

Women's physical health concerns (29%) were related to the healing, pain, and infection of birthing incisions. Teachings and recommendations were made to promote women's comfort (e.g., Tylenol, sitz baths). In more serious situations (e.g., infection, heavy bleeding, post-partum depression) women were referred to their family physicians.

Nurses taught, provided literature, and support to mothers with breast feeding questions and difficulties. Frequency of feeding, latching, positioning of baby, and painful breasts and nipples were areas commonly addressed by PHNs. Women were also taught by nurses about the importance of increased fluid and caloric intake during breast feeding.

Infant health issues commonly included: infant breast feeding (44%) and bottle-feeding (28%), nutrition (44%), immunization (35%), and infants' overall health or general appearance (30%) (see Figure 16). Signs of baby's dehydration, and the importance of providing feedings every two hours was commonly discussed with mothers. Nutritional guidance about weaning, the addition of solids, and the use of vitamin supplements was a frequent field of teaching. Nurses also educated mothers about their babies' health care needs such as: cleaning the umbilical cord and caring for circumcisions, ensuring sufficient weight gain and hydration, and attending to babies with jaundice, colic, rashes, or fever. Immunization schedules were often reviewed with mothers.

Figure 16
Infant Concerns (N=232)



Source: DPH File Review

Background characteristics of families with identified health concerns were generally no different from those with none. However, mothers

with more than one child were found to be significantly less likely to report a concern (84%) in comparison to those mothers with a first born child (94%). This finding supports the importance of PHNs maintaining their current practice whereby home visits are offered to all first time mothers. Providing one-on-one teaching and support early on in a woman's parenting life helps to reduce anxieties often experienced by new mothers, while promoting critical health education and caretaking skills.

<u>Assessment Activity #2</u>: To complete a Risk Factor Assessment (RFA) with all families of new babies who agree to the G.T. program, as soon after birth as possible.

Once a family agrees to join the Growing Together program a clinical interview is conducted by a Growing Together worker. The structured interview is guided by a Risk Factor Assessment Questionnaire (See Figure 17). It takes approximately one hour to complete the questions which are generally informally addressed with clients during a home visit. Answers to questions are often filled in later in order to normalize the conversation and reduce the sense of intrusiveness sometimes experienced by participants of formal interviews. A casual approach to the questions of interest ensures clients proceed at their own pace and comfort level. Typically, the interview takes two to three visits to complete.

The Risk Factor Assessment interview was developed in order to assess risk in four areas: the child, parental functioning, parent-child interaction,

Figure 17
Sample Page of the Risk Factor Assessment

<u>GROWING TOGETHER, ST JAMESTOWN PROGRAM</u>

<u>RISK FACTOR ASSESSMENT</u>

I. INFANT VULNERABILITY

1. Normalcy of pregnancy - **How was your pregnancy? Did you have any problems with your pregnancy?**

( ) 2. Pregnancy was normal
( ) 1. Complications were experienced
( ) 9. Missing information/refuse to answer

2. Type of problem with the pregnancy - **What kind of a problem did you have with your pregnancy?**

( ) 0. 0. No problem with pregnancy
( ) 0. ( ) 1. Yes 1. Toxaemia
( ) 0. ( ) 1. Yes 2. Threatened miscarriage
( ) 0. ( ) 1. Yes 3. Placenta previa
( ) 0. ( ) 1. Yes 4. Anaemia
( ) 0. ( ) 1. Yes 5. Excessive vomiting or nausea
( ) 0. ( ) 1. Yes 6. Excessive staining or blood loss
( ) 0. ( ) 1. Yes 7. High blood pressure
( ) 0. ( ) 1. Yes 8. Surgeries
( ) 0. ( ) 1. Yes 9. Infections
( ) 0. ( ) 1. Yes 10. Diabetes
( ) 0. ( ) 1. Yes 11. Other illnesses
( ) 0. ( ) 1. Yes 12. Other (please specify): ____________________

3. Birth experience - **How was your labour and delivery?**

( ) 1. Mother describes her experience as very negative
( ) 2. Mother describes her experience as acceptable
( ) 3. Mother describes her experience as very positive
( ) 9. Missing information/refuse to answer

4. Problems with labour and delivery - **Did you have any problems with your labour and delivery? What kind of problems did you have?**

( ) 0. 0. No problem with labour and delivery
( ) 0. ( ) 1. Yes 1. Labour was very long
( ) 0. ( ) 1. Yes 2. Infant showed signs of stress
( ) 0. ( ) 1. Yes 3. Emergency cesarean
( ) 0. ( ) 1. Yes 4. Premature labour
( ) 0. ( ) 1. Yes 5. Labour induced
( ) 0. ( ) 1. Yes 6. Hemorrage
( ) 0. ( ) 1. Yes 7. Cord around neck
( ) 0. ( ) 1. Yes 8. Cord presented first
( ) 0. ( ) 1. Yes 9. Breech
( ) 0. ( ) 1. Yes 10. Other (please specify): ____________________

family and other sociodemographic factors. Needs expressed by the family are also considered. Using this transactional approach, the number and types of strengths (or protective factors) and risks are considered. Based on the RFA information, the case is presented during a clinical team meeting and the assigned level of risk is considered along with appropriate interventions.

One hundred and six Risk Factor Assessments (RFAs) were successfully completed in 1996, which is comparable to other years. Approximately one-third of the RFAs were completed by Growing Together Public Health Nurses with the remainder being completed by Hincks-Dellcrest Centre affiliated staff. Eighty percent of the RFAs were completed by the time the child was four months of age, thereby ensuring early developmental feedback to the Growing Together team about infant health and parent functioning.

A small proportion (10%) of the RFAs applied to children who were over the age of one year. In most cases, these families were new to the neighbourhood or were referred by outside service providers because of concerns. The RFA interview has typically been administered to accommodate these toddler aged children. Many items in the RFA, however, are not developmentally appropriate, such as breast feeding questions, thereby making the obtained information briefer for these older children. Developmental or behavioural difficulties are noted by the interviewer in these instances.

Workers experienced few times when they were unable to complete an RFA interview with a family.

Workers a

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trust [in sc

Some felt this was a direct result of the program's inclusion of an Intake Worker, responsible for making initial contact with all referred families. Loss of clients occurs more frequently at this early stage of contact rather than later, once a home visitor becomes involved. Reasons for not successfully completing an RFA were generally related to clients being fearful of outside interference in their lives.

Although some clients prefer to meet workers at Growing Together or local meeting spots, the vast majority of RFA interviews were conducted in the homes of clients. Meetings outside the home were organized for clients who are uncomfortable with having people in their home, or for those involved with violence or criminal activities.

Workers feel positive about home visiting

It [home visiting] reaches families with young children and [from] different backgrounds who otherwise would not come into a centre or clinic. By coming into an office you remove them from their situation, by being in the home you may see problems play themselves out more quickly.

Some people are so needy at the beginning that a group would be overwhelming. They need the individual support and teaching. Also, they need individual assessment and a plan done which I cannot do in a group. Home visiting is an opportunity to do individual counselling, [but] it is misconstrued as being some kind of deluxe service. But we are not delivering a cadillac service, we are trying to deliver a professional service in the most therapeutic way possible -- in the home, reducing barriers, and offering confidentiality.

With the families I work with [who are high risk] it is the only way I would have made a connection to begin with. It is also the only way I can ensure any kind of regular contact with those families [and] it provides me with information I would not get otherwise. When a mother tells me she does not use physical discipline but I see a belt over the back of the sofa it is an entry into the conversation. In some cases it is the only way I would have contact with the fathers, in one case it led to family counselling.

Because we're in the clients own environment, it's a safe environment [for them], so it is non-threatening and it's convenient for them.

A lot of the families we see do not have the organizational skills or the language skills to get it together and get out the door, so it is a lot easier just to have someone come to them. For new immigrants it can be an issue of negotiating langauge barriers. For families that are really high risk it may be a motivational thing where they do not feel it would be helpful to go to a treatment centre but they find it much less threatening to have someone visit them.

They are at home and more at ease and they can remember what to ask you. They can learn better when they are more at ease [too].

Both workers and clients felt positive about home visiting and the importance of this intervention strategy when working with new parents. Workers commented that parents who are isolated, lack English speaking skills, or have disorganized or chaotic lives, benefit greatly from having workers come to their homes. Home visiting was seen as an outreach strategy for reducing barriers between parents and workers and encouraging a feeling of safety and ease for clients. Visiting families where they live also allowed workers to see life circumstances, needs, and family interactions as they really were.

Difficulties associated with home visiting were also identified by workers. Clinicians felt that defining their role as something different than a friend and maintaining appropriate boundaries was at times challenging. Distractions and interruptions at times impeded the work. Less mentioned by workers, but clearly a concern, is the issue of personal safety.

Workers also noted difficulties associated with home visiting

There are times when there are a lot of distractions, but that is what they're dealing with, that's realistic. Sometimes you do have a feeling you are being watched or judged by other family members. That just makes me work harder to get them involved in the process.

What is less positive [about home visiting] is that it blurs the boundaries between the client and the professional so it may be more difficult for the client to see you as a professional and know your role as different from a friend.

I have one client, for whom home visiting would be regressive, she needs to be able to keep regular appointments and organize herself. It is beneficial for her to have a place and a time that is her own. So that mother meets me regularly here [at the project site].

The challenge of home visiting can be the distractions and the difficulty of keeping things focused. There is a thin line between the social visit and actual therapeutic work that is being done. It's much more difficult to define when you're doing a home visit.

One of the negative elements [with home visiting] can be the boundary issue. It can feel, for example, intrusive for some clients and too permissive for some. I think it puts more pressure on the clinician to be clear about the boundary issue.

I have a connection with people I see [through home visiting] that is difficult to establish with people you see in the office. You have access to more of their lives, you have a more intense experience of 'being' with them. For that same reason it is complicated in term of building a connection. That capacity for closer connection facilitates entry into the program for some people. [But] I wonder if some people feel too exposed for that same reason.

Home visits are helpful for mothers

Interviewed clients were receptive to home visits and found them very helpful. Mothers learned about their children's development and child rearing practices. Loneliness experienced by women who were home alone with children was also alleviated by worker visits.

Visits were extremely helpful because they added to my knowledge, especially here in Canada. Practices about [how to] raise children are different here [than in my homeland].
41 year old, Filipino Mother of 6 month & 8 year old.

It made me feel happy [to get visits]. I learned how my baby grows up. It was good to talk to her [the worker from G.T]. ...You learn a lot about your baby [and] also about groups [available] at Growing Together.
29 year old, Eriteric Mother of 22 month old.

Sometimes I am doubtful of my baby's development. At the visits I can ask the person about my doubts. I can get answers and learn and clear my doubts about my baby. ... It's good because you learn about your baby [and] the people who come to visit you are nice.
32 year old, Tamil Mother of 1 year old.

I needed someone to talk to about my being frustrated with my child, I didn't know what to do from one day to the next. ...They have valuable information for you [on] how to bring up your baby, how to feed your baby, what formula to give your baby and [about] Growing Together programs.
43 year old, Canadian Mother of 3, 8 and 20 year olds.

I was lonely at home, I didn't know anyone here [in Toronto]. Then I got the baby, [the worker from G.T.] was like my mother. I was happy. She knew about our culture so she could explain things. ...You can ask her anything and she can find out the answers and she can speak the language if you can't speak English.
36 year old, Tamil Mother of 2 and 5 year olds.

<u>Assessment Activity #3</u>: To determine the risk and protective factors of a family and assess each family as low, moderate or high risk.

As explained in the preceding section, risk factors identified through the RFA fall under four distinct headings: infant capacities, past and present parent functioning, parent-child interactions, and family and sociodemographic factors. Both risk indicators and protective factors are examined in each of these four areas and are summarized in the Risk & Protective Factors Checklist which appears opposite (see Figure 18).

Figure 18
Risk and Protective Factors Checklist

		High Risk Indicator	Protective Indicator	Check for extreme risk factor
	Infant capacities			
C1	Birth Weight	( ) Low	( ) Within normal range	
C2	Growth	( ) Lack of Growth	( ) Adequate growth	
C3	Temperament	( ) Difficult: hypersensitive/ difficulty being calmed/ irritability/ difficulty habituating	( ) Easy: cuddly/ easily calmed/ habituates/ self regulates	
C4	Genetic Constitution	( ) Biological difficulties	( ) No difficulties	
C5	Medical/ Physiological	( ) Problematic	( ) Physically healthy	
C6	Developmental Milestones	( ) Delays	( ) Age appropriate	
C7	Feeding	( ) Problematic /fussy	( ) Feeds regularly and easily	
C8	Others			
	Parenting Functioning Past and Present			
P1	Resolution of difficulties in family or origin	( ) Traumatic history unresolved	( ) Has resolved any previous traumatization	
P2	Intellectual functioning	( ) Low	( ) Average to high	
P3	Education and Employment Record	( ) Poor	( ) Satisfying	
P4	Perception of infant	( ) Negative	( ) Positive	
P5	Locus of control	( ) External locus	( ) Internal locus	
P6	Mental health	( ) Current and past psychopathology and/or psychiatric illness	( ) No psychopathology or psychiatric illness, current or past	
P7	Use of drugs and alcohol	( ) Current use of drugs or alcohol	( ) No current use of drugs or alcohol	
P8	Age	( ) Teenage or older mother	( ) 20-39 years old	
P9	Enculturation	( ) Criminal activities/ antisocial behavior	( ) Prosocial behaviour/ involved in community	
P10	Bonding to child	( ) Poor quality	( ) Good quality	
P11	Care of previous children	( ) Neglect and/or abuse	( ) Good parenting	
P12	Physical health	( ) Chronic illness	( ) Healthy	
P13	Parenting knowledge	( ) Lacking	( ) Adequate	
P14	Present relationship	( ) Enmeshed or distant relationship	( ) Secure in relationship	
P15	Self perception of parenting ability	( ) Unrealistic: inflated or diminished	( ) Realistic	
P16	Developmental expectations of child	( ) Low or unrealistically high	( ) Realistic	
P17	Self esteem	( ) Low	( ) Average to high	
P18	Ego functioning	( ) Inadequate development of ego functions	( ) Adequate development of ego functions	
P19	Use of service system	( ) Present or past failure to use system	( ) Appropriate use of system	
P20	Social integration	( ) Isolation and lack of trust in others	( ) Well integrated with others	
P21	Accepting responsibility of infant/ child	( ) Difficulty accepting responsibility	( ) Willingness to accept responsibility	
P22	Resolution of abuse	( ) Unresolved	( ) Resolved	
P23	Depression	( ) Depression	( ) No depression	
P24	Other			
	Family and Sociological			
F1	Marital status	( ) Having no partner/ single parenting	( ) Supporting partner	
F2	Number of children	( ) Several children	( ) Number of children desired	
F3	Social and extended family networks	( ) Inadequate	( ) Supportive	
F4	Neighbourhood	( ) Chaotic/ violence / addiction	( ) Supportive	
F5	Socioeconomic status	( ) Poor	( ) Middle/ upper class	
F6	Immigrant status	( ) Recent, illegal or refugee	( ) Integrated with culture	
F7	Linguistic	( ) Poor	( ) Well integrated	
F8	Structure & routines in home	( ) Lacking	( ) Well established	
F9	Life events	( ) Negative events outweigh positive events	( ) Positive events outweigh negative events	
F10	Resolution of marital separation issues	( ) Unresolved	( ) Resolved	
F11	Relationship of parents	( ) Very dysfunctional	( ) Supportive	
F12	Developmental status of other children	( ) Delayed	( ) Average or above	
F13	Conflict and anger management	( ) Parenting abuse, sibling abuse, violence in family	( ) Discussion and problem solving	
F14	Reference groups with respect to child development and/or discipline	( ) Favour harsh punishment, e.g. religious cult beliefs	( ) Favours good parenting and discipline practices	
F15	Unemployment	( ) Parent(s) distressed due to unemployment	( ) No unemployment/No distress due to unemployment	
F16	Other			
	Interactional Factors			
I1	Attunement to infants cues or signals	( ) Lack of attunement	( ) Attunement present	
I2	Affect with infant	( ) Lack of positive affect	( ) Positive affect present	
I3	Feelings/ attitudes towards infant	( ) Infant perceived as below average	( ) Infant perceived as above average	
I4	Response to distress in infant	( ) Insensitive/ ignores or overwhelms	( ) Sensitive and nurturing	
I5	Attributions of infant	( ) Negative or idealized	( ) Realistic	
I6	Encouragement of infant development	( ) Either pushes child too hard or does not provide enough stimulation	( ) Encouraging but not too overwhelming	
I7	Other			

Figure 19
Risk Factors - Infant Capacities (N=106)

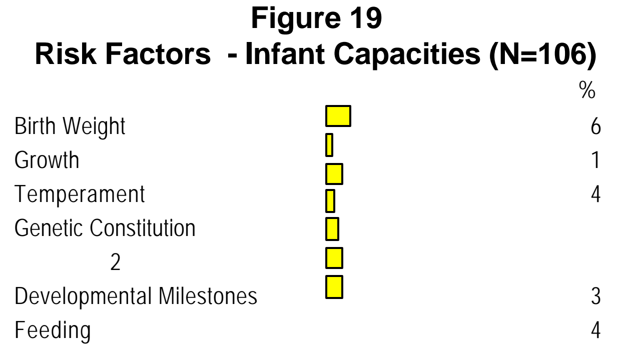
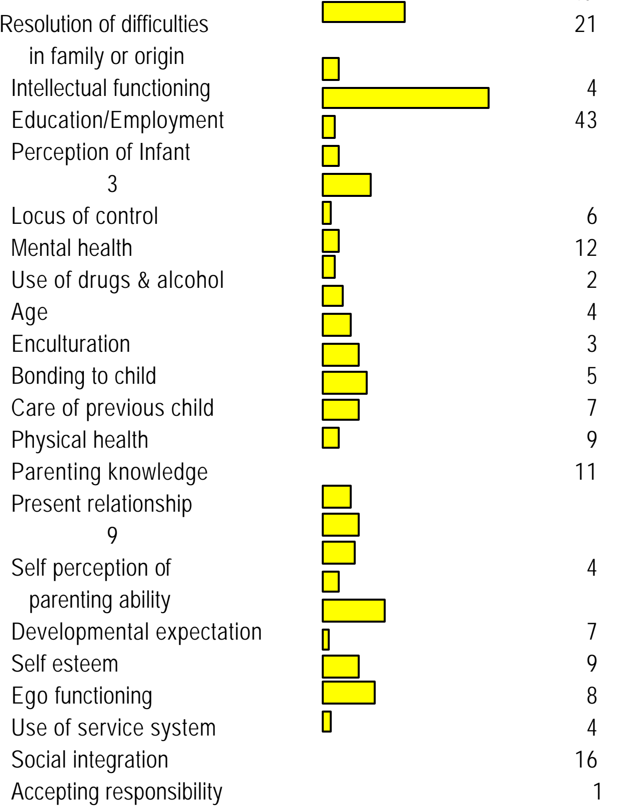


Figure 20
Risk Factors - Parent Functioning (N=106)



Indicators of child risk include: low birth weight, lack of growth, difficult temperament, genetic problems, medical/physiological problems, developmental delays, and feeding problems. As seen in Figure 19, the proportion of children identified in each of these areas is relatively small, with the most commonly identified risk to children being low birth weight. Due to the fact that the RFA assessment involves very young infants (i.e., new borns to a few months old), these figures would be expected to increase with age. For example, medical problems and developmental delays may only become apparent when the child is approaching six months to a year old and he/she fails to achieve the usual developmental milestones, and/or when the child is formally assessed with standardized developmental screens.

Indication that the health and development of a young infant may be at risk now or at some future point is often more reliably identified by observing the characteristics and experiences of parents themselves. Parent risk factors documented through the use of the RFA appear in Figure 20.

Frequently identified parent risk factors include social (i.e., poor education/employment record, poor social integration), mental health (i.e., unresolved past trauma, mental health problems, maternal depression), and parenting issues (i.e., limited parenting knowledge).

The Risk Factor Assessment also explores family indicators of risk. Examined family factors are listed in Figure 21. Common risk factors identified in Growing Together families include those related to poverty (i.e., low SES, living in an unsafe neighbourhood, distress as a result of unemployment), isolation (i.e., recent immigration, limited social support networks, poor language skills, being an unsupported parent), and family of origin dysfunction (i.e., conflictual relationships between parents of origin).

Observed interactional patterns of parents often reflect a lack of attunement and negative or idealized attributions toward their infant (see Figure 22).

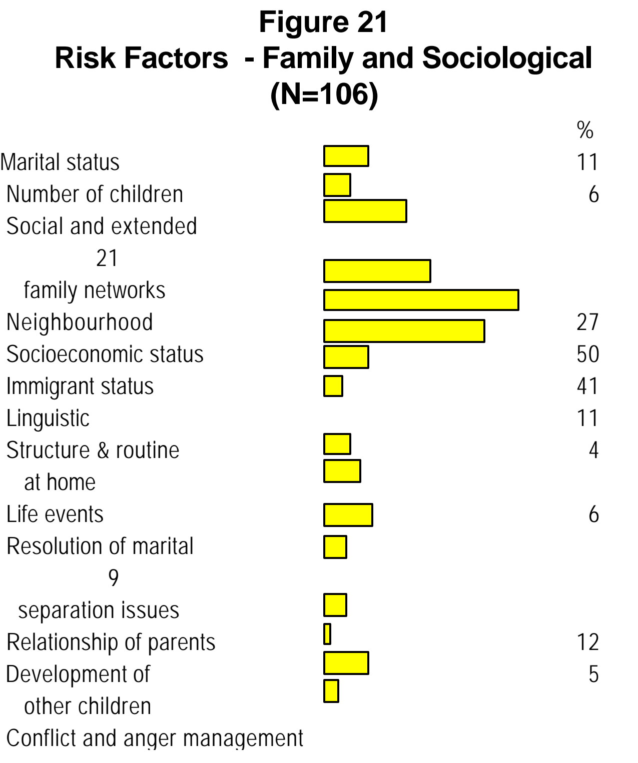


Figure 21
Risk Factors - Family and Sociological
(N=106)

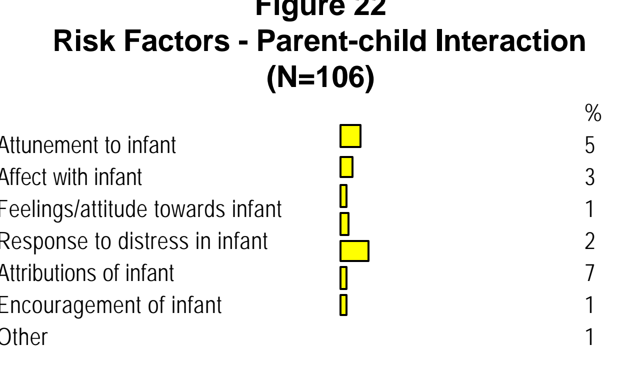
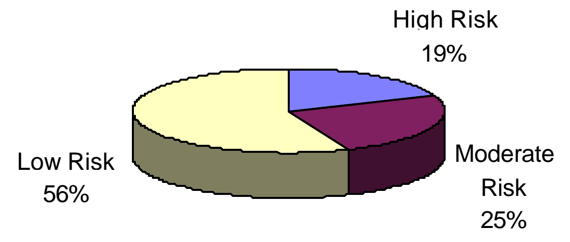


Figure 22
Risk Factors - Parent-child Interaction
(N=106)

Figure 23
Risk Status for Growing Together Families*
(N=106)



∗ Based on new intakes for who an RFA was completed in 1996.

Determination of a family's risk category, as low, moderate or high risk, is dependent on the balance of identified number and severity of risk factors and relevant protective factors. Clinical judgement plays a part in this determination at the time when the RFA is presented to Growing Together team members. At weekly team meetings members summarize the details of their cases according to RFA interviews. A level of risk is proposed on the basis of the RFA scoring protocol. At that time, a family's risk level may be further explored and debated amongst team members.

In 1996[8], the Growing Together population fell into the three risk level categories as follows:

- 56% low risk
- 25% moderate risk
- 19% high risk

(See Figure 23 for risk category breakdown)

[8] Proportions are based on 106 new clients who completed RFAs in 1996. This proportion is generally similar to that of the entire Growing Together population.

The average number of risk indicators for the high risk group was twelve, with an average of five factors for the moderate and two for the low risk groups. Of the moderate risk group (n=27), nearly half (44%) were considered to be in need of follow-up and meriting home visiting clinical services (see Table 8).

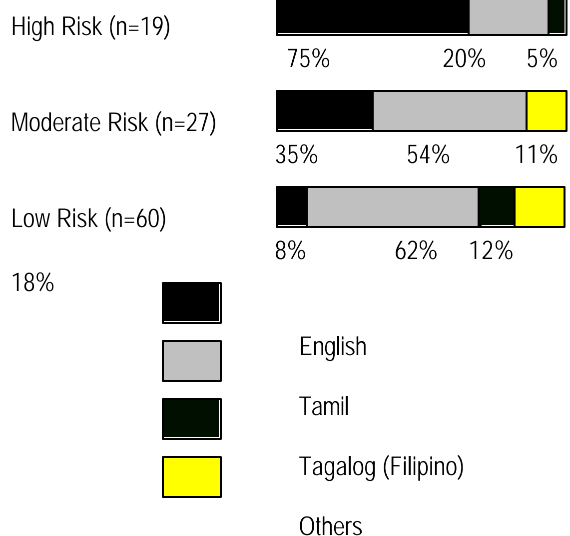
Marital status and language spoken at home were the only background characteristics that were significantly different between the three risk groups. Parents rated as being at high risk were more likely to be single parents (45%), whereas the moderate (65%) and low risk group members (95%) were more often married.

Among all dominant ethnic groups at Growing Together, English speaking families showed a predominant proportion (75%) in the High Risk group with the rest of this group being Tamil (20%) or Tagalog (Filipino) speaking (5%). Those rated as moderate risk were largely Tamil (54%) or English (35%) speaking families. In contrast, the low risk group was extremely diverse and included all ethnic groups seen at Growing Together. Tamil (62%) and Tagalog (12%) speaking families represented the two dominant ethnic groups among low risk families (See Figure 24).

Table 8
Follow-up after RFA by Risk Group

Percent	High Risk (n=19)	Moderate Risk (n=27)	Low Risk (n=60)
% receiving Therapist / Home Visitor Follow-up	100 %	44%	5%

Figure 24
Risk Status and Home Language (N=106)



A system for monitoring infants

A major obstacle to the delivery of appropriate early intervention services is the timely identification of infants and young children who are experiencing developmental problems. Timely identification requires establishing comprehensive Child-Find programs and monitoring systems and using economical, valid, and culturally sensitive assessment tools to deal effectively with the increasing numbers of children identified as at risk for developmental delays resulting from medical and environmental factors. One economical and effective option for timely identification is to involve parents' as first-level screeners of their young child's development. ... Because professional assessments are expensive and are usually not performed at regular intervals, the use of more cost-effective means (e.g., parent-completed tools) may be better suited for the periodic monitoring of early development. ... The ASQ system relies on parents to observe their child and to complete the simple questionnaires about their child's abilities. ... The questionnaires are designed to be completed by parents when a child is 4, 8, 12, 16, 20, 24, 30, 36, and 48 months of age, with optional questionnaires available at 6 and 18 months. Children are identified as needing further testing and possible referral to early intervention services when their ASQ scores fall below designated cut-off points.
Squires, LaWanda, & Bricker, 1995., p.3 & p.5.

Assessment Activity #4: To assess and track infant and young children for developmental delays or problems, through the Infant Monitoring System,

The Infant Monitoring System (IMS) was established at the project in the fall of 1996. The System involves mailing the *Ages and Stages Questionnaires*, (designed to identify infants and young children who show potential developmental problems), to parents who complete and return a package every four to six months until the child reaches the age of three. A final questionnaire is completed at four years. Parents may also request assistance with questionnaire completion.

In all, there are 11 questionnaires mailed over 4 years, which each take 10-30 minutes to complete. Each questionnaire contains 30 developmental items, written in simple language. Additionally, materials have been translated to Tamil for the purpose of the Growing Together project, since non-English speaking families from Sri Lanka make up 19% of the project's population. Thirty-five percent of those completing the IMS request the translated version. Question items cover five areas of development: communication, gross motor, fine motor, problem solving, and personal-social. Scoring involves converting parents "yes", "sometimes" and "not yet" responses to 10, 5, or 0 points respectively. The total score for each area is then compared to empirical cut-off points. Feedback is provided to parents in the form of a letter, reassuring parents that their child's development appears to be proceeding as expected, or with a phone call when developmental problems are identified. In this situation, parents

are invited to attend an appointment at the Developmental Clinic for further developmental screening.

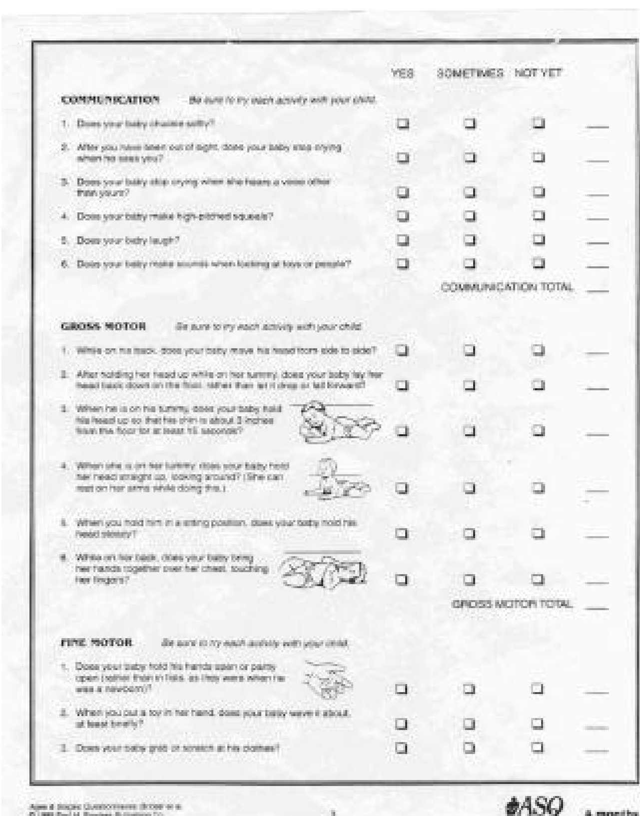
The purpose for establishing the IMS was twofold. First and foremost, it was believed important to engage parents in the monitoring and assessment of their children's developmental progress. Parents completing the questions are encouraged to take time to try each prescribed activity with their child and observe whether they can perform the behaviour. In so doing, parents acquire critical information about their children’s development and, as well, are educated about appropriate developmental expectations. Additionally, parents acquire rich information about their children's health and development. Providing a means to tap this knowledge is a useful developmental screening approach. (See Figure 25 for a sample page of the questions).

A second reason for implementing the *Infant Monitoring System* was based on the program's goal of tracking the development of infants and young children in the St. Jamestown community. For a variety of reasons, many parents contacted about the project soon after the birth of their child are disinterested in joining a group, receiving home visits, or attending the Developmental Clinic. Opportunity to participate in an aspect of the program that requires no more than receiving and returning questionnaires in order to monitor their child's development is an attractive alternative. Families who, in the past, would have been lost as prospective clients are now joining this aspect of the program.

The infant monitoring system (IMS) is used by G.T. workers to track children's development

A family was visited by a clinician and the RFA was completed. The clinician had concerns about the development of the baby and they were brought to the Developmental Clinic. Mild delays were identified. I was brought in to do a brief intervention with the baby and the 3 year old daughter who had an eating problem. When the intervention ended because of the mom going back to work the baby was signed up for the IMS to help monitor his development. It also provided mom with information about what her son should be able to accomplish. Also, it ensured that the baby would be tracked in case she [mom] would not be able to come in for follow-up at the Developmenal Clinic.
Growing Together Worker

Figure 25
Sample Page of the Infant Monitoring System



	YES	SOMETIMES	NOT YET	
COMMUNICATION *Be sure to try each activity with your child.*				
1. Does your baby chuckle softly?	❑	❑	❑	___
2. After you have been out of sight, does your baby stop crying when he sees you?	❑	❑	❑	___
3. Does your baby stop crying when she hears a voice other than yours?	❑	❑	❑	___
4. Does your baby make high-pitched squeals?	❑	❑	❑	___
5. Does your baby laugh?	❑	❑	❑	___
6. Does your baby make sounds when looking at toys or people?	❑	❑	❑	___
		COMMUNICATION TOTAL		___
GROSS MOTOR *Be sure to try each activity with your child.*				
1. While on his back, does your baby move his head from side to side?	❑	❑	❑	___
2. After holding her head up while on her tummy, does your baby lay her head back down on the floor, rather than let it drop or fall forward?	❑	❑	❑	___
3. When he is on his tummy, does your baby hold his head up so that his chin is about 3 inches from the floor for at least 15 seconds?	❑	❑	❑	___
4. When she is on her tummy, does your baby hold her head straight up, looking around? (She can rest on her arms while doing this.)	❑	❑	❑	___
5. When you hold him in a sitting position, does your baby hold his head steady?	❑	❑	❑	___
6. While on her back, does your baby bring her hands together over her chest, touching her fingers?	❑	❑	❑	___
		GROSS MOTOR TOTAL		___
FINE MOTOR *Be sure to try each activity with your child.*				
1. Does your baby hold his hands open or partly open (rather than in fists, as they were when he was a newborn)?	❑	❑	❑	___
2. When you put a toy in her hand, does your baby wave it about, at least briefly?	❑	❑	❑	___
3. Does your baby grab or scratch at his clothes?	❑	❑	❑	___

3 ASQ 4 months

Between September 1996 and August 1997, 105 parents of infants and young children enrolled in the IMS. Ninety-eight of these families have continued to complete the packages and have their children's development tracked through the System. Only seven families have withdrawn over this period. Of this group, three families chose not to participate by failing to return the questionnaire. The remainder had either moved from the area or their child had reached the System's termination point (i.e., 48 months of age).

Over one-half (53%) of those joining the IMS enroll in the System at the time of the RFA interview. Others enter into the System once they are attending groups and/or services at Growing Together.

Background characteristics are not specifically collected from those families taking part in the Infant Monitoring System. The Risk Factor Assessment (RFA) is relied upon for this purpose. Ninety-four percent of IMS involved families did complete the RFA. Families who participate in the IMS are representative of the Growing Together population, with no particular subgroup showing greater participation in the service.

Eleven percent of the 105 families, who are taking part in the IMS are involved solely with this service. Others enter through this aspect of the program and subsequently join other Growing Together activities.

Of the 105 child participants, 33 were identified as having developmental or health difficulties (31%).

Inf

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Other

Note: Chi

Shown in Figure 26, the predominant area of concern for children was their gross motor ability. Under the category 'other' concerns included other developmental problems, weight and feeding problems, various infections, and general health concerns.

The outcome of cases identified through the IMS as being suspect or of concern is currently not documented in the Management Information System database. Ten of the thirty-three cases in which concerns were noted were selected for the purpose of examining the prescribed intervention and outcome of cases. Review of the Developmental Clinic files showed three of the ten families contacted refused to come to the Clinic as suggested. One child was scheduled for surgery and was to be recontacted at a later date. Another child had feeding issues and mother felt it unnecessary to attend the Clinic as there were no identified developmental concerns. The third family simply refused to attend the Clinic. The remaining families did attend Clinic appointments in order to have their children seen by the Paediatrician and Developmental Psychologist. All but two of the children were identified as being on track in their development; two had possible delays. The first of these two children showed delays on the Developmental Inventory for Screening Children (DISC) in the areas of auditory attention and memory, gross motor and receptive language. The second child showed possible delay in the areas of self-help and gross motor. These children were referred on to a worker with the TLC[3] project who recommended developmental activities to enhance the problem areas. All families were encouraged to

Workers need more feedback about concerns identified through the IMS.

Because I'm not on site [at the project] , I rely on the client to tell me when a problem has been found [through the IMS]. I think there needs to be an improved way of communicating about it -- between developmental clinic staff [who follow-up with a child identified on the IMS as having a concern] and the family worker.

Parents appreciate the Infant Monitoring System

If she [my child] doesn't walk, I am worried she doesn't walk and I have to ask many friends [why she is not walking]. When I get the [Infant Monitoring] questions I know why she doesn't walk and when she will walk.
34 year old, Tamil Mother of 2 & 5 year olds.

[The IMS] helps you understand how she [my child] is growing, [and] what she is suppose to do. You feel happy. It [the IMS questionnaire] tells you what she is supposed to do at that [particular] age.
29 year old, Eritrian Mother of 22 month old.

[The questions] help me understand what my baby is doing at four months, eight months, [and] twelve months. It makes me feel happy to see my baby doing these things on the [IMS] form.
29 year old, Tamil Mother of 16 month old.

have their children re-tested and examined at the Clinic in the future months.

Overall, workers have found clients to be receptive and interested in the Infant Monitoring System. However, a number mentioned a need to hear back about those cases where a developmental assessment appointment was requested because of identified concerns. Feedback between Clinic staff and family workers needs to be improved.

Clients felt positively about the IMS service. All those interviewed said the questions helped them to understand their child better. Questions educated mothers about their child's developmental milestones. Questionnaires were found to be easy to complete and return. The fact that it was available in Tamil and was free to return, made the service even more attractive to some. Mother's quotes appearing opposite, illustrate the opinion that the Infant Monitoring System provides important educational information about child development.

***Assessment Activity #5*: To have parents visit the developmental clinic as soon as possible after the birth of their child and complete a developmental assessment with any referred children.**

The Developmental Clinic operates one-half day per week at the St. Jamestown project site. Team members include two Public Health Nurses, as well as a Paediatrician, and Developmental Psychologist. A speech pathologist, employed one day per week through the TLC[3] program, is available for those Developmental Clinic cases where follow-up is requested. Developmental and speech assessments are provided at times outside Clinic hours in order to accommodate the schedules of parents.

One hundred and twenty-eight children were seen by Developmental Clinic staff during the year 1996. (Ninety of the cases[9] were new to the clinic with the remainder being children who had initially come to the clinic prior to 1996).

Over one half of the children who came to the Clinic (55%) were under the age of 12 months at the time of their first visit. Approximately 30% were under 6 months of age.

Children were referred to the Clinic primarily by a Growing Together worker (60%). Word of mouth about the service led to a few clients being told about the Clinic by family members or they referred themselves to the Clinic (14%). Four percent were referred to the Clinic by outside service providers

[9] Developmental Clinic file review data are based on the 90 cases that were new to the clinic in 1996.

(e.g., Victoria Day Care, CAS). No clear referral information was provided in the files of the remaining clients.

Reasons for a child's initial referral to the Clinic included: general medical check-up (11%); specific health concern (32%); developmental assessment (34%); and, other reasons which included monitoring the child's health and development (5%). Again, the remaining client files did not clearly explain why the child had initially been referred to the Clinic; Developmental Intake/Referral Forms were absent in approximately one-quarter of the files.

Review of 1996 Developmental Clinic case files (N=90) showed that 55% of the children seen were identified as having a health and/or developmental problem.

Families who come to the Clinic begin by taking part in an initial intake visit with the PHN. At this time, nurses complete a developmental history with the parents and discuss any health concerns and problems. This approach has helped to ensure that the family is properly assessed prior to seeing the Paediatrician, Psychologist, or Speech Pathologist. Typically the client would attend a half hour session with the PHN and schedule subsequent visits accordingly. In 1996, the Developmental Clinic's PHNs saw a total of 92 children; 15 children saw only the PHN while the remaining children were screened by a PHN prior to seeing other clinic staff.

PHNs often addressed parents' nutritional questions, such as appropriate feeding schedules for babies. Parents were educated about when to

introduce solids and homogenized milk, the importance of breast feeding, and how to deal with baby's constipation through diet. Adjusting baby's sleep patterns was another commonly covered topic. The importance of immunization and dental check-ups was reinforced with parents, as was the importance of stimulating, playing with, and holding the baby. Developmental Clinic nurses also identified those families where further home visiting was needed.

Having PHNs see families before other Clinic staff has resulted in some concern because of the time required by families to attend the various appointments. Certain families find it difficult to get to the Clinic due to organizational difficulties while others have children who need immediate attention. Asking such families to attend more than once in order to have their child assessed may lead to their failure to return. Under these circumstances intake information can be completed by the family's worker during home visits rather than by the Clinic nurse. In this way families can see the doctor or psychologist at the time of their first visit to the Clinic. Families may also schedule back-to-back appointments with the PHN and other Clinic staff. This option may, however, present a problem in that young children often become irritable and difficult to assess when attending hour long appointments. Regardless of these issues, most of those who make appointments at the Clinic do attend; in 1996, 86% of children attended their scheduled appointments, and of the 456 clinical appointments made, 332 were successfully completed (73%).

In 1996, the Clinic's Paediatrician provided 59 children with 79 visits. Issues addressed by the Paediatrician included: identifying developmental delays and assessing the physical progress of delayed children; children's physical health and feeding problems; discussing with parents family planning, baby's sleep patterns, breast feeding issues, and baby care; and assessing children for hyperactivity.

Developmental assessments were conducted with 71 children. Most were seen two to three times for a total of 187 appointments. The Diagnostic Inventory for Screening Children (DISC) was most frequently administered (48%). Also administered were the Brazelton Neonatal Assessment Scale, Rorschach, WPPSI-R, and the Bayley Scales of Infant Development. Referred for developmental screening were children with concerns related to speech delays, emotional maladjustment, and attention/behavioural difficulties.

The Speech Pathologist was on staff for only six months during the year 1996. A gap in service occurred while the position was being re-filled. Over the course of six months, 12 children received a total of 38 speech appointments for language delays.

Seven clients were interviewed about their satisfaction with the services they received at the Developmental Clinic. Two parents felt the services were below expectations and had not sufficiently assisted them and their children. The remaining parents said the Clinic had provided reassurance about their child's developmental progress and as well had assisted with the early identification of problems.

Attending the Developmental Clinic

I came to Growing Together because she [my child] didn't drink milk after I stopped breast feeding. She [the PHN] said many children don't eat and drink well. She told us to feed her foods with calcium. So if she drinks less milk, it's ok.
34 year old, Tamil Mother of 1, 8 & 13 year olds.

I visited [the Pediatrician] and [the Developmental Psychologist]. The [Psychologist] said my boy was developing fine and that other examinations were not necessary at his age. It was helpful because knowing my child's development [is on track] is important to me. It is reassuring [to know] how my baby is doing.
41 year old, Filipino Mother of 6 month & 8 year old.

My oldest child is so far behind. [The Developmental Psychologist] told me that his [developmental] stages were at 12 months and he was already four years old. I didn't know where to turn [for help] before. I asked my doctor and wasn't satisfied with the answers [I got] until [I found] Growing Together.
39 year old, Filipino Mother of 6 month, 2 & 6 year olds.

<u>Assessment Activity #6</u>: To monitor and track children's developmental progress through the Developmental Clinic during the first five years of life.

On-going developmental assessment and tracking of children ensures the early identification of any possible problems which might impede children's present or future development.

The Developmental Clinic has been operating as part of the program since 1993. Over the course of its history, 332 children have been assessed by the team. Only sixty-six of these cases have been closed, the majority of which were closed due to the family having moved from the community.

It is difficult to assess the follow-up success rate of cases seen at the Clinic as families may attend sporadically and according to need. While the ideal would be to have all parents bring their children on a yearly basis for ongoing screening until the age of five years, this is not always possible for families faced with multiple demands and crises. Additionally, staff shortages make it virtually impossible to follow-up with all those who do not successfully attend the Clinic.

Existing statistics accumulated through the Management Information System show that 63% of the Clinic's cases have attended follow-up appointments[10].

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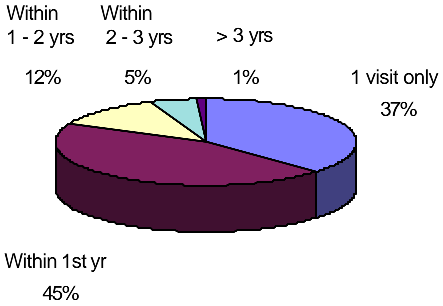
[10] Follow-up appointments at the Developmental Clinic are defined as more than one appointment being attended. Number of clinic appointments ranged between 2 and 31.

Figure 27 illustrates the proportion of the clients who attended the Clinic for follow-up appointments over the years. As shown, the largest group of families (45% n=148) came to the Clinic for follow-up visits within a one year period. As of yet, they have not returned. Sixty families attended more than one visit. Most of them visited over the course of one to two years (n=40), the remaining in two to three years (n=16) and three or more years (n=4). Of the total number of families who use the clinic (N=330), 122 came only once. Among this group 37 visited more than two years ago and will probably not return for a follow-up visit. Forty families visited within the last year and probably will attend follow-up visits in future.

Figure 27
Follow-up Visit from Developmental Clinic (N=330)



Circumstances surrounding cases where families did not return after the initial visit were examined by conducting a random review of twenty of these Developmental Clinic cases. Most of the families attended the clinic, and received assessment and/or counselling from the PHN, Paediatrician, and/or Psychologist. Only one four year old boy was noted as having possible developmental delays in the areas of gross motor and social development. Consultation occurred with the family's Infant Mental Health Worker around methods for stimulating the child, but the child did not return for follow-up assessment as recommended.

The majority of families came to the clinic with specific concerns, such as feeding difficulties, nutritional questions, or developmental issues. Mothers were provided with the needed information, and appropriate referral was made to family physicians, outside services, or other G.T. services.

4.3 Summary

The Growing Together program has been extremely successful in contacting and reaching out to all families with infants and young children in the St. Jamestown area. Although, only 24% of the families with newborns receive a risk assessment, the majority of mothers are contacted (87%) by PHNs and given the opportunity to receive services and have urgent questions answered. This initial contact may facilitate future entry into the program. The high level of preventative work that is carried out in the immediate post-partum period is likely to avoid the development of more significant problems and mitigate against the need for more intensive early intervention strategies further down the road.

Efforts to inform as many mothers as possible about the Growing Together program, and to provide services at the convenience of families, has successfully encouraged families to participate in the program. As a secondary purpose, program intake procedures allow Growing Together to collect data on the families who use the services and consequently provides information on program clientele. Efforts to maintain data on families is an ongoing challenge due to confidentiality issues and the need to respect some clients' reluctance to share information or sign consent forms. It is important for Growing Together workers to maintain a balance between these needs.

Efforts to monitor the development of children and to identify any changes in risk status are crucial to any early intervention program. The initial risk status of a family at the time of their baby's birth is

important. However, risk status may change in a positive or negative direction, as a family's circumstances change. A developmental or medical issue may be identified for example, or a new developmental stage may create significant challenges for parents. Staff shortages and the numbers of families involved in the program have made monitoring of all children and families unmanageable. Still, tracking efforts have allowed a number of children to be identified early on as needing extra stimulation. Tracking services may be preventative and help parents avoid the need for future intervention, while others allow the child to receive early intervention services.

Two of the most significant initiatives for ongoing monitoring of the development of children, the Developmental Clinic and the Infant Monitoring System (IMS), are seen as non-threatening and consequently become preferred services for many families. The IMS continues to grow in popularity and is often an entry point into the program. It is also a vital link for many families who do not come to the centre initially or in some cases on an on-going basis. Apart from its monitoring purpose many parents find the developmental information it provides extremely useful.

V Prevention, Early Intervention, and Health Promotion Initiatives

Discussed in this Chapter are those activities undertaken at Growing Together that fall under the headings of education, support and advocacy, as well as counselling and therapy.

5.1 Parent Education

Informing parents about child development and appropriate parenting practices is an important objective of the program. Appearing opposite, in Table 9, the program's *Education Activities* and related process questions are listed. Considered are two *Education Activities*: 1) educating and supporting mothers in the areas of breast feeding, prenatal care and nutrition; and, 2) promoting good parenting skills by educating parents about child development and healthy life style choices.

Table 9
Procedure Sheet:
Parent Education Component

Program Activities	Evaluation Question	Data Collection Strategies
1. To promote with mothers the benefits of breast feeding and healthy nutritional practices during pregnancy and after on an individual and or group basis	1a. How many GT clients attend the prenatal group, before and after delivery? 1b. How many new mothers at GT do and do not breast feed their babies (for how long?, reasons why or why not?). Related factors(i.e., culture, age, number of children)?	1a. PHN statistics on number of prenatal group participants, and file review or interviews to determine characteristics. 1b. MIS records (RFA) on number of mothers breast feeding, reasons, characteristics.
2. To promote and support good parenting skills by educating parents about child development, bonding and attachment issues, and life style practices.	2a. How many parents receive and respond to the mail out tracking system (IMS)? Do they find it educational/ informative? 2b. How many parents are attending parenting groups that inform about or directly foster child development? 2c. How much time	2a. Computer records on number receiving Infant Monitoring System. 2b. MIS and interviews with group leaders on the number of parents attending parenting groups. 2c. G.T. and D.P.H. file reviews, on amount of time spent with individual clients on parent/child

The benefits of breast feeding

The importance of breast milk in protecting the newborn from infection is recognized worldwide. Infant morbidity and mortality have been directly affected by a decline in breast feeding. Health care providers are working toward meeting the national goal of increased initiation and duration of breast feeding.
Orlando, 1995, p. 678.

Breast-feeding seems to be particularly protective against some of the common childhood conditions such as eczema, otitis media and iron-deficiency anemia as well as benefiting neurodevelopment in premature infants. In addition, recent reviews of the overall reduction in risk of death with breast-feeding suggest that one-third to one-half of current infant deaths in North America are because of a failure to breast-feed fully (i.e., to give breast milk exclusively for the first 4 to 6 months of age, then breast milk plus solid food until 12 months).
Frank & Newman, 1993, p. 34.

Early intervention helps promote breast feeding

Public health units should consider promoting and enhancing the breast feeding services that mothers rated as being the most helpful. At one month, home visits were preferred by mothers. During the initial postpartum period, going out of the home to obtain services may be difficult for many new mothers. Breast feeding difficulties, such as problems with latch, often requires physical assistance to correct. At three months and six months, the telephone hot line became the first choice. At this time, the assistance required can be easily accessed by telephone. …… "The onset of lactation (i.e., an increase in maternal milk supply) usually takes 2-3 days with effective breast feeding …… Consistent, appropriate professional support during this crucial early period can make a difference in long-term breast feeding success."
Bourgoin, Lahaie, Rheaume, 1997, p.241.

***Education Activity #1*: To promote with mothers the benefits of breast feeding and healthy nutritional practices during and after pregnancy on an individual and/or group basis.**

Health promotion is a vital job responsibility of PHNs. The promotion of breast feeding and proper nutrition with mothers-to-be and new mothers is of particular importance since there are considerable health benefits associated with breast feeding. Support of women early after delivery offers greater insurance that women will successfully breast feed their new born. As noted in the previous *Assessment* section, early telephone contact and/or home visiting was provided by PHNs to 312 women in the year 1996; detailed postnatal sheets about child and mother were available on 232 families. According to postnatal sheet information, 89% of the mothers were breast feeding at the time of PHN contact (n=206). Early support, by means of instructional teaching and/or literature, was given to a large number of mothers who had either a breast feeding (n=102) and/or nutritional concern (n=91).

Public Health Nurses also promote breast feeding and nutrition with St. Jamestown women who are pregnant through the *Prenatal Group*. Women meet once a week to prepare healthy meals while talking about different issues like healthy eating, fetal development, pregnancy changes, infant care, birthing practices, and other topics of interest.

Sixty-one women attended the *Prenatal Group* at the Growing Together site in 1996. Approximately three-quarters remained with the group until three

months after delivery, when their membership with the group ended. *Prenatal Group* participants are generally new immigrant women, primarily Tamil, who have limited English speaking skills. Most are married, having their first child, and from a lower income bracket. Food vouchers for women to buy nutritious food and milk while pregnant are distributed as part of the *Prenatal Group*. Women receive food vouchers worth ten dollars each time they attend the group. This aspect of the program is seen by staff and the women themselves as an important incentive for group attendance.

Upon completing the *Prenatal Group*, mothers are encouraged to join the *When Baby Comes Home Group*, a group offered by PHNs to support parents as they adjust to their new baby. Mothers meet weekly to discuss topics like: breast feeding, nutrition, safety, growth and development, caring for children through illness, and the importance of routines. The *When Baby Comes Home Group*, offered in both English and Tamil, saw a total of 44 women in 1996 (English =25; Tamil =19).

The transition between the *Prenatal* and *When Baby Comes Home Groups* seems difficult for some. Women's long affiliation with the *Prenatal Group*, the group's provision of food vouchers, and the older age of baby at the time of group termination, may be factors contributing to women's resistance in joining another group.

Figure 28
Feeding Patterns of
Growing Together Mothers (N=106)

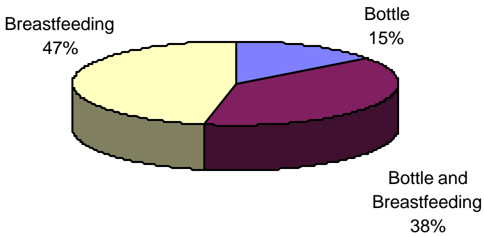


Figure 29
Reasons for Breast feeding (N=88)

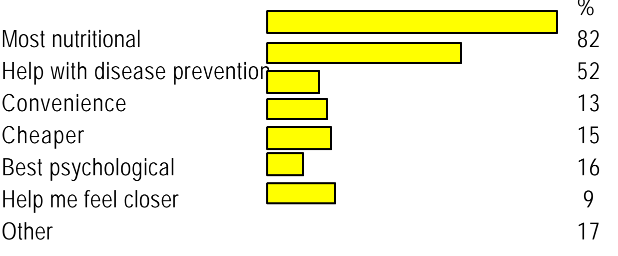
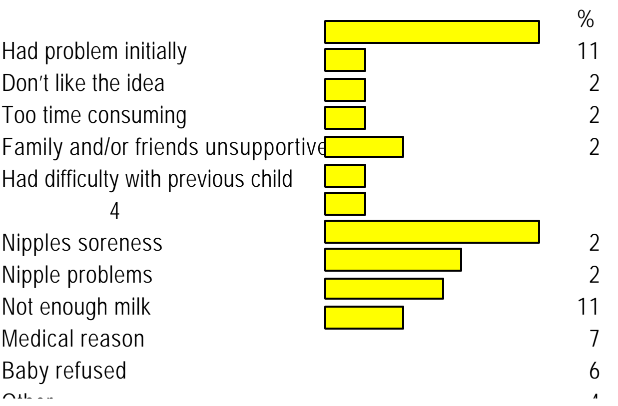


Figure 30
Reasons for Not Breast feeding (N=55)



Generally, the mothers of St. Jamestown are successfully breast feeding their babies. According to Growing Together's 1996 Risk Factor Assessment data, approximately 85% of mothers breast fed their infants (see Figure 28). Slightly less than one half of this group were supplementing with bottle feedings.

Reasons given for choosing to breast feed appear in Figure 29. Commonly noted reasons were that it is the most nutritional choice for baby and that it helps in the prevention of illness. Women who bottle fed (15%) rather than breast fed their babies reported their choice had largely been due to: initial difficulties with breast feeding (11%), not having enough milk (11%), medical reasons (7%), and baby refusing the breast (6%) (see Figure 30). Early intervention by PHNs at times of doubt and difficulty is clearly essential for breast feeding mothers.

Women's ability to cope with the physical and emotional demands of breast feeding also impact women's decision about whether to breast or bottle feed. According to 1996 RFA information, mothers likelihood of breast feeding increased as the number of risk factors in their lives decreased in number. In other words, women rated as being at "extreme risk", according to the Growing Together RFA instrument, were least likely to breast feed, whereas women identified as having "no risk" factors in their lives all breast fed their babies. Women who had a greater number of children at home were also less likely to breast feed than were women who had an only child or one additional child. Finally, Tamil women were most likely to rely

on breast feeding as it is a common practice in their homeland.

<u>Education Activity #2</u>: To promote and support good parenting skills by educating parents about child development, bonding and attachment issues, and healthy life style practices.

Parenting groups, the Infant Monitoring System, and one-on-one educational counselling during home visits, are all Growing Together services which offer parents opportunity to learn about effective parenting practices and child development.

Parent education or child activity groups inform parents about and/or directly foster child development[11]. Parenting groups offered at Growing Together include: the Prenatal Group, the H.E.A.R, When Baby Comes Home, Nobody's Perfect, the Mother's Club, and the Young Mom's Group. (See Table 10 for group descriptions and attendance rates).

Combined, these six parenting groups saw a total of 155 participants[12] over the course of a one year period (1996). Group participants have, for the most part, been women, with only a few fathers having attended the *When Baby Comes Home Group* and the *H.E.A.R Group* over the years. According to group leaders, men's presence can make the discussion of some topic areas

Table 10
Parenting Group Attendance

G.T. Parenting Groups	Total Attendance
Prenatal Women meet once a week and prepare a healthy meal while talking about different issues healthy eating, fetal development, pregnancy changes, infant care and other topics of interest. Food coupons are given out to promote a balanced diet.	61
Helping Encourage Affect Regulation (H.E.A.R.) This group program for parents of young children helps them avoid or deal with behaviour problems and enhance their child's development. Weekly topics include: the development of self-esteem; attachment; compliance; caring and communication. Parents are provided with useful parenting techniques and a supportive environment in which to learn about parenting young children.	22
When Baby Comes Home (English and Tamil) A support group offered by PHNs and to assist parents in adjusting to a new baby. Parents meet weekly for 6 weeks. Some of the topics covered: What to do when your baby cries; breast feeding; nutrition for you and your baby; safety; things to do to help your baby learn; growth and development; taking care of a sick baby; learning about resources in your community; developing your child's self-esteem; exercise for you and your baby ; getting your life back after the baby comes; establishing routines.	44 English = 25 Tamil = 19
Nobody's Perfect A program for parents of children from birth to 5 years provided by PHNs. Parents meet weekly for 6-8 weeks. Topics discussed include: normal growth and development; maintaining your child's health; recognizing illness; accident prevention and safety; handling common behaviour problems; meeting your own needs as parents.	10
Mother's Club A club for mothers of children between 6 months and 2 years. As babies grow and start to be able to move around on their own, they keep their mothers busy, trying to make sure they are safe and secure and that they have a chance to see what it's like to explore the world for themselves. On Wednesday afternoons (1:30 - 3:00pm) mothers can come and bring their children to share with other moms how they are helping their growing babies and toddlers to become themselves.	8
Young Mothers Group The group is geared to young women with children in the St. Jamestown area. The group provides knowledge, information and support for its members. Each group will vary, to focus on the needs and desires of the specific group members. Topics may include: child development information; dealing with health, welfare and housing issues; as well as relationships and stress management. Mothers involved in the group	10

[11] Further discussion of the impact of Growing Together parenting groups appears in the *Short-Term Impact Study Report* (1998).

[12] This number may include repeats, as some women may have attended more than one of these groups.

uncomfortable for women participants, such as when contraception is being discussed in the *When Baby Comes Home Group.*

Attempts have been made at the project to address the educational and parenting needs of fathers. A *Father's Group* was successfully run twice. A total of twelve fathers attended the eight week sessions. Unfortunately, subsequent efforts to organize the group have failed, in part, because male therapists join the project team infrequently.

Fathers may be present when G.T. workers conduct home visits. Therefore, fathers may have the opportunity to receive parenting education at these times. Tailored to meet the needs of each family, parents are free to discuss parenting issues and concerns with a Growing Together Infant Mental Health Worker or PHN during the home visits. It is difficult to calculate the amount of time spent during home visits educating parents about child rearing, child development, and life style issues. Content analysis of the 1996 Growing Together case files (N=78), for example, showed 21% of parents received parenting and 16% child development counselling. Health and lifestyle issues were noted as having been discussed with 13% of families. These estimates are probably low, however, as clinical case notes reflect general discussion themes and not all aspects covered during a home visit.

An additional parenting education service is the Infant Monitoring System (IMS), the program's mail out developmental tracking package. As previously explained, the IMS is expected to contribute toward a parent's knowledge of their child's

development. As of May 1998, a total of 188 Growing Together parents were enrolled in the System. According to client interviews, (discussed in Chapter IV), mothers believed the Infant Monitoring System provided them with important information about children's development.

Table 11
Procedure Sheet:
Support & Advocacy Component

Program Activities	Evaluation Questions	Data Collection Strategies
1. To address the fundamental life needs of families (housing/ nutritional and childcare needs)	1. How many families have been referred to advocacy services at G.T., due to daily life needs? Characteristics of clients?	1. Monthly computer records on advocacy workers time with clients. Random file review to determine characteristics of families requiring advocacy services.
2. To provide a stimulating childcare environment and allow children to meet other children.	2a. How many children participate in childcare services at G.T.? Age range, activities? 2b. How many families are involved with the toy lending library?	2a. Child care statistics and interviews with child care providers about children's activities. 2b. G.T. statistics on the number of families using the toy lending library.
3. To encourage parents to attend groups and activities to meet other people in the community	3a. How many parents participate in social support clubs? (e.g., Filipino Group, Friendship Club)? 3b. Client satisfaction with the manner in which social	3a. Number of participants from group leaders and interviews with selected leaders regarding the characteristics of group members. 3b. Interviews with selected social group participants to

5.2 Support and Advocacy

Addressed in this section are three *Support and Advocacy* activities: 1) advocating for clients around their daily needs (i.e., housing, finances, immigration); 2) providing families with a stimulating and supportive childcare environment while they attend groups; and, 3) encouraging parents to attend groups and activities in order to meet other community members. (Table 11 summarizes these activities and related research questions).

<u>Support and Advocacy Activity #1</u>: To address the fundamental life needs of families (i.e., housing, nutritional, financial, and childcare needs).

Within a one year period (1996), 134 families were referred to the project's Community Home Visitor Worker who specializes in advocacy services. In addition to this number, Growing Together Workers, in general, assist individual clients as needs arise. Eleven of fifteen G.T. workers indicated during interviews that providing clients with advocacy services was a significant aspect of their job at the project. By offering parents practical assistance with their everyday needs parents are better able to focus on the demanding task of parenting. Daily life needs, such as shelter, food, and child care, are common reasons for advocacy intervention.

Many families who come to the project require assistance to access services: they need help opening bank accounts, getting phone services restored, and receiving Legal Aid. Supportive assistance is offered by the Advocacy Worker and G.T. workers, who make telephone inquiries or write letters on behalf of clients, and/or accompany them to outside agencies, such as food banks.

Difficulties arise for clients faced with complicated application procedures and appeals. This is particularly true for parents whose first language is not English, or for those who are new to the country, or illiterate. Assistance with Welfare, Employment Insurance and Disability Pension claims and appeals, is commonly required as is assistance with accessing subsidized day care, OHIP, and school applications.

Advocacy services also help clients obtain those household and personal items needed to improve the quality of families' lives. Beds and dressers, baby strollers and cribs, eyeglasses, and medication, to name a few, are frequently needed commodities.

Advocacy activities

[My worker] helps me any time I have a language problem. I bring permission forms or Government letters and she helps me read them and understand them.
29 year old, Tamil Mother of 16 month old.

I wanted day care [services] for a year. [My worker] called them [subsidised day care services] all the time. I just filled out the forms and finally got it a year after. [Also, my worker] wrote a letter for me [to the housing authorities] and talked to the lady [superintendent] here at my building about my housing transfer.
32 year old, Canadian Mother of 2, 5 & 9 year olds.

Working with children in Child Care at G.T.

Child Care has] two functions. One is to provide a safe place for the children while parents attend groups. The second part has been to optimise, while the children are here, their growth and development.... The main issue [in working with children who come to child care] is separation. Dealing with this sensitively is important [and] recognising that the parents are perhaps as anxious as the kids are. [We work with parents] by normalising it, [and by teaching them they should] expect that children have a reaction to being separated from their parents. We reassure parents that their own and their children's feelings are understandable. [We encourage parents] to see separation as a process that doesn't all have to be done at once. It's something that varies from child to child. Some take much longer and shuttle between mom and the child care [room]. [Gains made by children who attend Child Care at G.T. are] learning to separate from mom, [rule] compliance, language skills, and social skills.
G.T. Child Care Co-ordinator

Use of volunteers for child care services

It's been very labour intensive [to use volunteers in the Child Care room]. If you take the students who volunteer their time, the time they can put in here is so little that it's barely worth while given the amount of time put into training, supervision, and scheduling. And with the community volunteers -- it hasn't been very efficient so far, but I still think it's worthwhile. It encourages more and more parents to come and volunteer and it helps them to feel more useful [to the program].
G.T. Child Care Co-ordinator

***Support and Advocacy Activity #2*: To provide a stimulating childcare environment, which allows parents to attend programs and allow children to meet others their age.**

The *Child Care Program* provides young children with a safe and healthy environment where they have opportunity to learn about cooperation and play in a structured setting. By attending the *Child Care Program*, children also have an opportunity to slowly adjust to separating from their parents. While the *Child Care Program* allows parents to attend activities, parents are also taught appropriate adult-child interactions as demonstrated by childcare staff. Furthermore, having time away from their children helps reduce parents' stress and increases their sense of support.

Statistics on the number of families using the *Child Care* services are not available for the year 1996, as the service was not fully established at that time. Upon moving to the current site, a child care room was opened. Within a one year period (1997), 166 children[13] (from 132 families), who were between 2 months and 5 years of age, were cared for at the program's facilities. On a weekly basis, an average of 16 children attended the program. This number varied from week to week depending on which groups and community events were operating.

Largely, it is volunteer workers who staff the *Child Care* room. Volunteers are trained and supervised by the Child Care Co-ordinator. Organizing workers' schedules to meet the needs of group

[13] This number represents individual children in 1997.

participants is at times difficult and time consuming. Ensuring volunteer workers are consistently available and remain motivated to take part in this important service, even when group attendance may vary from week to week, is often difficult. Additionally, evening and weekend groups are generally not possible, in part because volunteer child care workers are not interested in weekend commitments.

A service which compliments the educational work done with parents regarding the importance of stimulation and play, is the *Toy Lending Library*. The *Library* allows families to borrow a toy or book for each child in the family over a ten day period. In 1996, the Growing Together *Toy Lending Library* served 72 children (53 families). Six of the parents interviewed had used the *Library*. In their opinion this is an important service in that it allows parents to explore which toys their children enjoy and learn from.

Borrowing toys is a nice option

It [the Toy Lending Library] is an important service. Especially since it is an economical help. Rather than buying, you borrow toys. It is better to borrow than to buy. The toys are good quality toys, they are good learning toys.
41 year old, Filipino Mother of 6 month & 8 year olds.

[It is an important service for parents] because some people can't afford toys. You see a new toy for 10 days and then you can get another toy when you bring it back. [It is really great].
43 year old, Canadian Mother of 3, 8 & 20 year olds.

***Support and Advocacy Activity #3*: To encourage parents to attend groups and activities to meet other people in the community.**

Through group participation it is expected that a greater sense of support and community will develop among families living in St. Jamestown. Growing Together groups include: therapeutic, skills and recreation, psychoeducational (parenting), community development, and friendship/support groups. Groups were attended by a total of 229 parents in 1996[14]. Parents comments confirm their gaining support from group leaders and from others who attend.

At the request of parents, two groups were developed that were specifically directed toward parents socializing with one another. Filipino mothers who attended the *Filipino Group*, for example, met and planned weekly group activities. In 1996, twenty-four mothers and their children attended this Group. Another seven families came to Saturday afternoon social meetings of the *Friendship Club*. Both groups are not currently operating, partly due to the desire of group members to have meetings during evenings or weekends, placing added demands on group leaders. Skills and recreation groups also help bring parents together. In 1996 the *English Club* helped 20 women practice English speaking skills and learn about Canadian culture. A few new additions since 1996 have been, the *Craft Group, Relaxation Group, and the Computer Class.*

Parents gain support from group participation

The [Parenting Group I attended] was good. I met new moms and we talked and stuff. I sometimes asked other mothers a few questions about their babies and they would tell me [their experiences].
32 year old, Canadian Mother of 2, 5 & 9 year olds.

I liked coming [to the Support Group] to make friends and [long term] relationships. It is [an] easy [feeling].. we can talk about my country's traditions. We talked about differences between my country's culture and the culture here.
29 year old, Tamil Mother of 16 month old.

The [Support Group I attended with other] parents had games and stuff and it was nice to know people I didn't know before. ... My kids could get involved with other kids too.
39 year old, Filipino Mother of 2 &6 year olds.

[14] Parents may be counted more than once if they attended more than one group during the year.

Community development groups such as the *Community Kitchen* and larger community events are organized to facilitate community involvement and stimulate understanding among community members. These activities are discussed in Chapter VII under the heading *Community Development*.

5.3 Counselling and Therapy

The program offers parents of young children opportunity to discuss and address mental and physical health issues. Counselling and therapy activities provided by PHNs, Infant Mental Health Workers, and the program's staff psychiatrist include: 1) giving parents an opportunity to build a caring relationship with a G.T. worker and move toward resolving any early life trauma, 2) offering psychiatric services to parents displaying psychiatric problems, 3) providing crisis intervention services, and, 4) providing infant/child focused interventions to encourage optimal child development. (See Table 12 for a summary of Counselling/Therapy activities).

Table 12
Procedure Sheet: Counselling & Therapy Component

Program Activities	Evaluation Questions	Data Collection Strategies
1. To offer parents of young children, identified as moderate and high risk, opportunity to develop a caring relationship with a GT worker(s). To promote healthy relationships within and outside of the family and offer opportunity to resolve parenting issues resulting from unresolved trauma, abuse and loss during their early lives.	1a. How many home visits, telephone contacts, office visits does a client receive on a monthly basis? (What family characteristics influence mode, discipline of case worker, and rate of contact?) How long doesPHN typically remain involved with a case or get re-involved. (Circumstances) 1b. How many parents are receiving individual or couple counselling? What are the characteristics, circumstances and issues of these parents? 1c. How many parents display symptoms of unresolved childhood issues? Characteristics and circumstances? 1d. How do moderate/high risk clients perceive the therapeutic intervention they are receiving? Is it useful? What is the most helpful thing about having a GT worker?	1a. MIS records on staff monthly contact - Hincks staff. Random review of case files to determine influences over rate and mode of contact. 1a. Full File review of DPH records regarding mode and rate of contact with families. 1b. G.T. File review on the number of parents receiving individual/couple conselling. 1c. MIS records on RFA questions related to unresolved trauma. 1d. Interviews with high-risk clients about their satisfaction with services (i.e, friendliness, sense of support, concrete help, a caring person, professional advice etc).
2. To provide psychiatric assessment, counselling and medication for parents who display symptoms of depression or psychosis.	2. How many psychiatric consultations have been requested? Characteristics of these clients? Is medication provided by staff or outside psychiatrist?	2. Computer monthly records on the amount of psychiatric services provided. Random file review on the characteristics of clients.
3. To provide crisis intervention when needed	3a. What proportion of time do staff engage in crisis intervention? Characteristics of families/problems? 3b. How often are Respite Care plans put in place for families in need and circumstances.	3. MIS and File review records on DPH and Hincks staff time spent on crisis intervention. File review to identify characteristics of these families, types of crises.
4. To provide infant/child focused interventions which encourage optimal physical, cognitive and emotional development	4a. How many children are receiving therapeutic interventions (type of intervention, and characteristics of children) 4a. How many parents and children are involved in parent-child therapuetic approaches (i.e., interactional coaching, behavioural approaches, developmental	4a. Full file review to determine type of interventions with children, characteristics of cases. 4a. Full file review at DPH to determine rate of involvement of Parents Helping Parents (Characteristics)

<u>Counselling and Therapy Activity #1</u>: To offer parents, identified as moderate or high risk, opportunity to develop a caring relationship with a Growing Together worker, and encourage the resolution of parents' own childhood trauma in order to promote healthy relationships within and outside of the family.

Families identified through the RFA as being at either 'moderate' or 'high' risk for negative child outcomes are offered opportunity to receive counselling and therapy from a G.T. worker. The course of action to be taken with a family is decided upon during team meetings when RFA interview material is discussed.

Situations related to physical health and health promotion are commonly referred to a PHN on the team whereas mental health concerns are referred to a Infant Mental Health Worker. Mental health issues addressed include bonding and attachment difficulties between parent and child as well as parents' past trauma. According to RFA data collected in 1996, 21 parents, or 20 percent of clients interviewed that year, displayed symptoms of unresolved childhood issues.

Research has clearly shown that both the number and type of risk factors are important to consider. Using the types of risk factors, protective factors, as well as the requests of families can be very useful in making decisions about the optimal type of treatment for a family.

Team members may be selected to work with a particular family because they share a similar culture and/or speak the family's native language.

Furthermore, there are those families with whom a number of G.T. workers become involved due to multiple needs being identified at the time of the RFA interview.

Clients interviewed about the counselling and therapeutic interventions received through the program said that having a worker was very beneficial. Feelings of emotional and instrumental support are clearly expressed in the mother's comments which appear opposite.

Counselling and therapy services

I have been meeting with [my G.T. worker] since 1992. It has been one-on-one with her on Tuesdays. We are very close, she is like a mother to me. I asked her to be in the delivery room with me for my third child.
32 year old Tamil Mother of a 1 year old.

It's been helpful [to have a G.T. worker] because I can talk to her about everything and I don't have to feel embarrassed. I have got so close to her.
43 year old Canadian Mother of 3, 8 & 20 year olds.

My worker helped me find services in the community. I asked her about [my child's] diarrhoea and what to do. I [also] asked when my baby should start sitting. [She] helped with [finding] daycare [services for me] when I had to go back to work. She gave me a list of places [day care centres] and helped me find a place in two or three days. She made a lot of phone calls. I am really grateful to her.
29 year old Eritrian Mother of 22 month old.

My home visitor has visited me since my baby was born. She helped me a lot. I didn't know there was a problem with my first child before [coming to G.T.]. I brought my son to G.T. and they asked me a whole bunch of questions and they found out he had a hearing loss problem. He is ok now.
39 year old Filipino Mother of 2 & 6 year olds.

Figure 31
Monthly Statistical Sheet

Growing Together Project

Individual Intervention Statistics

Month/Year:

Responsible Volunteer/Staff: ____________________

Name of client (please specify mom/child)	Case ID/File # (if available)	Date	Means of Contact	Intervention Strategies/Purpose

Remarks:

Means of contact	Intervention Focus
HV=Home visit	T=Therapy
TC=Telephone contact	C=Crisis Intervention
OI=Office Interview	R=Referals/Advocacy
CC=Collateral Contact	RA=Risk Assessment/Other Assessment
TS=Therapy session/ AssessmentSession	HP=Health Promotion
	OT=Other assistance, e.g. escort, translation, program introduction
	M=Monitoring

The project's Infant Mental Health Workers document on a monthly basis, the names of clients with whom they have worked, the type of intervention provided (e.g., therapy, crisis intervention), and the manner in which contact was made (e.g., telephone, home visit). (The G.T. Intervention Statistics Sheet can be seen in Figure 31). These data are recorded monthly as part of the G.T. Management Information System. Public Health Nurses maintain contact records at the Public Health Department office and not with the G.T. program.

Infant Mental Health workers, according to their monthly statistics sheets, provided 69 clients with 1275 therapy sessions during the year 1996. The sessions were conducted through 416 home visits (33%), 323 telephone contacts (25%), and 532 office visits (42%). As noted, these numbers do not include counselling services provided by Growing Together PHNs. Accuracy of the monthly *Intervention Statistics* was called into question during interviews with Infant Mental Health Workers. Terms, such as 'collateral contact' and 'other assessment', were not clearly defined in the minds of some. As well, there was a sense that some activities, such as intake telephone calls, were not consistently included in the monthly statistics. There is a need to reconsider the completeness of the categories and terminology used on the *Intervention Sheet*. Furthermore, the current *Intervention Statistics Sheet* does not require workers to document the type of therapy provided. The G.T. file review, which offered a means for examining this question, showed that fifteen percent of parents (11 of 75 cases) received individual counselling and four percent (3 of 75 cases) were involved in couple counselling. Clinical files, however, may not explicitly state the therapeutic actions of workers and therefore this figure is likely to be an underestimate.

It was determined, based on information obtained through the 1996 DPH file review, that 219 clients received counselling from PHNs during that year. Most of these families (79%) were discharged before the end of one month of service. Long-term PHN involvement was evident in 73 cases (21% of PHN cases). The majority of these mothers (85%) were counselled an average of 71 days and for the

most part, were involved in the Healthiest Babies Possible (HBP) program and/or were visited pre- and post- natally by the nurses. HBP is a home visiting program directed at women who display maternal dietary & nursing risk.

Cases brought to the G.T. team by PHNs for program referral are often discharged by nurses at that time, or soon thereafter. If the estimated risk to the child is in the moderate to high range, a family that agrees to the program would be referred on to an Infant Mental Health worker for follow-up or, if low risk, to other program services such as a group or the Developmental Clinic.

There are situations when PHNs and Infant Mental Health Workers, as well as other workers with the program, become simultaneously involved with a family. According to the G.T. clinical file review, thirty-one families (41%) were found to be receiving services from more than one G.T. worker. Unfortunately, it is not possible at this time to know, through the Management Information System, which cases PHNs are involved with since their work is not documented at the project. PHNs and Infant Mental Health Workers have two different case filing systems for documenting work with the same family. Tracking all those involved with a case is therefore difficult if not impossible as a result. This concern is further discussed in Chapter 6.

<u>Counselling and Therapy Activity #2</u>: To provide psychiatric assessment, counselling and medication for parents who display symptoms of depression and/or psychosis.

A Psychiatrist, who is part of the G.T. team, sees clients, both individually and in group sessions, who have therapeutic needs and, as well, provides workers with psychiatric consultation as requested. Assessment of depression and psychotic features in parents and behavioural, emotional problems in children, are common reasons for referral. The prescription and supervision of medication by the Psychiatrist is critical to both workers and families since outside referral would result in considerable service delay.

Review of the 1996 G.T. clinical case files (N=75) revealed four cases in which mention was made of the Psychiatrist's involvement. Again, the completeness of these files as a reliable data source must be called into question. Anecdotal evidence from team members suggests greater use of Psychiatric services than reflected by this number. Unfortunately, monthly activities or staff consultation with the program's Psychiatrist are not documented at this time and are therefore not available through the Management Information System.

Crisis intervention offers therapeutic opportunities

Although a crisis situation is neither an illness nor a pathological experience and reflects a realistic struggle to deal with the individual's current life situation, it may become linked with earlier unresolved or partially resolved conflicts. This may result in an inappropriate or exaggerated response. Crisis intervention in such situations may provide multiple opportunity to resolve the present difficulty, to rework the previous difficulties, and/ or to break the linkage between them.
Golan, 1986, p. 296-7.

Counselling and Therapy Activity #3: To provide crisis intervention when needed.

Crisis intervention work involves the immediate response of a worker to situations threatening a family's health and well-being. Common circumstances requiring this level of intervention include situations of violence or abuse, marital discord, sudden illness or death in the family, and situations that threaten a family's quality of life, such as the receipt of an eviction notice or food shortages. Crisis intervention efforts are directed toward alleviating the immediate stresser so as to stabilize the family and allow members to return to their previous functioning as quickly as possible.

Infant Mental Health Workers, (according to monthly intervention statistics), engaged in crisis intervention an average of eight times per month during the year 1996. This work was based on the needs of eighteen families. All families were rated as being at either high (79%) or moderate risk (21%) for negative child outcome at the time of the RFA interview. Most were English speaking (71%), single mothers (64%). Seventy-one percent of these mothers were caring for more than one child.

Crisis intervention provided by PHNs was traceable only in cases where there had been long-term involvement. In 44 cases *Family Health Records* had been completed and detailed notes were content analysed for evidence of crisis work. Nine families (20%) were identified as having received 18 crisis intervention responses during the year 1996. Again, this number is likely an underestimate of such interventions, since it was

difficult to specifically interpret the presence of crises in clinical files.

A number of clients enter into the G.T. program when seeking assistance at times of crisis. Thirty-two families joined the Growing Together program in the year 1996, because they were seeking the assistance of the program's Advocacy worker. Emergency situations involved an immediate need for food, free medical care, legal, and financial assistance.

Respite care is another important service, offered to parents at times of heightened stress. The service has been funded with a one-time grant provided to the CAP-C program through Victoria Day Care, a local community day care service. Parents in crisis can use the service for up to 3 days a week for short periods of time. This service does not replace a child being taken into care but can allow a difficult home situation to stabilise. This service has been used when mothers have gone to the hospital to have another baby; to help if a mother is ill or depressed by giving her a break, and in order to attend important appointments.

Referral to and use of Respite Care Services are not documented in the Management Information System at this time. According to the Day Care's records, sixty-one Growing Together families were provided with Respite Care services between April, 1995 and December, 1997 (Fifteen G.T. mothers were provided with respite child care services during the year 1996). Review of G.T. clinic files showed evidence of only two families being referred during that year. As already noted, content analysis

Workers feel, "Respite care is an incredibly important service for parents who have no extended family or friends capable of providing child care"

The client was having an [emotional] breakdown and needed to have someone take her child while she went for some doctor appointments and [also] to have a bit of a break [from him]. ... It was very important for someone to be able to step in and give her caregiver services and eventually subsidies [for day care services] were arranged.

This mom separated from her husband because of abuse. She had no support [system], like relatives [living around her]. Mom was somewhat depressed and the older child needed more stimulation after her baby was born. [Respite Care] was a great help because when you're not in a good mood you don't really feel like doing anything. It really lifted her spirits to know she wasn't alone.

This client had a baby with major developmental problems and she also had a toddler. She needed respite care for the older child because she was in and out of the hospital with the baby a lot. ... The parents were not able to spend a lot of time with the older child and were anxious that the older child was not receiving adequate stimulation. So their anxiety was reduced [once the family got Respite Care]. The child's behaviour also improved.

It felt developmentally appropriate for the child's world to expand to include other caretakers. [Respite care] was a god-send because she was in a very stressful situation and it provided a bridge for her to seek out a group day care program for her son. He began talking more, it really supported his capacity to relate to other children and adults.

of clinical files does not provide an accurate indication of intervention activities.

Asked about the usefulness of Respite Care services, G.T. workers commented that it was critical to provide temporary child care relief for parents living in a community fraught with isolation, poverty, and health crises. Most had relied on this service more than once during the course of their work. The service offered families various degrees of relief according to need. Critical was the fact that services were available day or night as well as on weekends.

<u>Counselling and Therapy Activity #4</u>: To provide infant/child focused interventions which encourage optimal physical, cognitive and emotional development.

Infant focused interventions provided by Public Health Nurses generally occur when infants are between two weeks and two and one-half months of age. In 1996, nurses provided infant focused interventions to 176 (49%) of St. Jamestown families with new borns. Infant interventions typically included guidance around feeding, nutrition, and general health (see Chapter 4, Figure 23).

Interventions provided by Infant Mental Health Workers at the project often occur after PHN involvement has ended. In certain high risk situations, both PHNs and Infant Workers are involved. The Management Information System does not include information on the therapeutic approach being used with any given family. It is not

possible, therefore, to determine through the MIS the number of children receiving therapeutic interventions or the number of parent-child dyads engaged in interactional coaching work. Therefore the 1996 G.T. file review was used to examine this question even though these data were found to provide an underestimate of intervention approaches. Eight children (in 75 reviewed case files) were identified through the files as having received therapeutic interventions. Approaches listed were play therapy, parent-child interactional work, and play focused on children's developmental delays.

In addition to these individual approaches, group work is done with children through: the Mother's Club which saw eight mothers and thirteen children in 1996; the Preschool Group[15] which saw nine children in 1998; and the Saturday Morning Club which saw 23 children in 1997.

[15] The *Preschool Group* and *Saturday Morning Club* began in 1998. The Preschool Group is a therapeutic play group offered to children identified as developmentally at risk, and is operated as part of the TLC[3] program. The Saturday Morning Club is offered to all children perceived as needing added opportunity to play in a structured setting and is primarily operated by volunteers from the Junior League Society.

5.4 Summary

The activities discussed in this chapter form the core of the Growing Together project once families accept the program and choose to be a part of the many aspects available. As noted, there are three main foci for the individual and group programs that are being offered.

- Parent education
- Support and Advocacy
- Counselling and therapy

As well, the programs can be offered in the home or at the centre, where they allow parents to have the opportunity to meet other parents and to form supportive networks. Taken together these programs are available to families who face multiple challenges, as well as those who would like information to care for their infants and young children in the best way possible.
Sometimes information offered at the right time can prevent small concern from becoming a major problem at a later time.

Having a broad range of possibilities for participation has been successful in meeting the needs of a large proportion of the families in St. Jamestown. As noted, the initiatives that are offered form a continuum which ranges from services that provide information of various kinds up to very intensive interventions which are provided for families with multiple challenges. Some of the aspects of the program which are particularly important given the high risk nature of the area,

include advocacy services to assist families with locating necessary services, as well as food, welfare, childcare spaces, etc. This aspect of the program has proved to be critical for many families. A core component is also the child care that is provided for children while their mothers attend groups. As outlined this aspect of the program provides children with extra socialization and stimulation while allowing parents to participate in various groups. Other services which are very well accepted by Growing Together families are the Toy Lending Library and Respite Care. The latter has been particularly important in high risk, very stressful situations.

VI Team Management and Development

Team Management, Referral Services, and *Team Development, Training, and Supervision* are examined in Chapter VI.

6.1 Case Management

Case management at the G.T. project involves the supervision of all staff, students, and volunteers. *Case Management* activities examined here include: 1) the review of RFA cases in team meetings, 2) the assignment of case files to all clients receiving interventions, as well as the development of a case formulation, and the completion of bi-yearly clinical case reviews, and 3) consultation as a clinical team on a weekly basis. These activities are summarized in the Procedure Sheet, appearing opposite (see Table 13).

<u>Case Management Activity #1</u>: To review, in Team Meetings, those cases for which an RFA has been completed, and evaluate the degree of risk, need and appropriate response.

One hundred and six RFAs were completed and presented for review in team meetings during the

Table 13
Procedure Sheet:
Case Management Component

Program Activities	Evaluation Questions	Indicators / Measures/ Data Collection Strategies
1. To review, in team meetings, families in which RFA has been completed and to evaluate degree of risk, need, and appropriate response	1a. How many risk assessments have been presented for review in team meetings? 1b. What factors influence how the case is managed at the time of risk assessment presentation?	1a. Review of team meeting notes for number of RFAs presented weekly, and by who. and/or computer records indicating date of RFA presentation? 1b. Interviews with staff managers and selected staff about case management at time of RFA presentation.
2. To open a case file for all families being followed, provide a formulation of each case and conduct bi-annual clinical case reviews.	2a. How many case files have been opened, what notes included, are there cases being followed by staff for which there is no Hincks or PH record on file? 2b. How many formulatations have been presented? Usefulness of this process? 2c. How many cases are presented during a case review period? Usefulness?	2a. Full file review, matching RFA case follow-up with opening of files at Hincks and PH (amount of time between cases being picked up and files being opened). 2a. Interviews with selected staff about the opening of files and exception when files are not opened. 2b. Interview team members to determine the number of G.T. formulations presented. 2c. Interviews with selected staff about the usefulness of case formulations. 2c. Interview workers, for number of case reviews conducted. 2c. Interviews with selected staff about usefulness of case reviews.
3. To conduct case consultation as a multi-disciplinary team on a weekly basis.	3a. How many team meetings have been held? 3b How many clients receive services from more than one staff person? Discipline of staff? Frequency of contact? 3c. How do staff learn about the involvement of another staff member with the same case? What procedure is followed when case consultation is needed? How useful is case consultation?	3a. Review team meeting records about number of meetings held, topics of discussion. 3a. Interviews with selected staff about the usefulness of case consultation in team meetings. 3b. MIS records on the number of clients where more than one staff is involved. 3b. Interviews with GT and PHN about their involvement is cases where other GT staff are involved. 3c. Interviews with selected staff about

Team meetings and RFA presentation

I think [the presentation of RFAs] is helpful in general. It gives the team an opportunity to ask questions that you may have missed. Or you may want some input into psychiatric issues or breast feeding, health, or nutrition issues that the nurses can be helpful with.

[Presentation of the RFA is good] because it provides a summary of the person [client]. It allows feedback to occur and suggestions for what [interventions] might be helpful. [As well], in high risk cases it offers support [for the worker], which I think is really important.

I find feedback from the team most helpful. There have been times when I say [a family is] 'mild risk', but for people listening, red flags would go up based on their experience [with similar cases].

year 1996. Although the number of RFAs reviewed during meetings is not documented in the minutes, it is estimated that two to four RFAs are presented weekly. Workers considered team input into the interpretation of RFA information to be exceedingly beneficial. Contributions of team members were valuable in helping to designate a risk level status and in recommending appropriate services for clients.

Factors influencing case management

Language is the first factor [influencing how a case is managed]. Our [program's] Tamil Home Visitor [for example] takes the majority of the Tamil cases. Degree of risk [is also important] -- [the ability to pick up a high risk case] may depend on a worker's case load. How long it takes to do the RFA [may also be important]. If a strong attachment [develops with the person who administered the RFA] [they may continue with the case]

Language spoken by clients and their degree of risk for a negative child outcome was seen by workers as being most influential in determining how cases are managed at the time of RFA presentation. Also mentioned was the volume of each worker's caseload and their ability to take on additional high need cases. A full-time Mental Health Worker with the project carries on average 15 moderate to high risk cases, requiring counselling/clinical intervention. PHNs generally each carry 8 to 10 cases at any given time. Cases where workers engage in considerable involvement with families prior to RFA completion often continued with the same worker. Cases where clients have difficulty communicating in English, was seen by some as resulting in less intense service provision for certain high risk families.

<u>Case Management Activity #2</u>: To open a case file for all those families being followed, provide a formulation of each case receiving intervention, and conduct bi-annual clinical case reviews.

Hincks-Dellcrest Centre case files are opened on G.T. clients following RFA presentation. At this time the intake form is inserted into the G.T. Management Information System and a copy forwarded to the Hincks-Dellcrest Centre Intake Worker. In 1996, 78 G.T. clinical files were opened and housed at the Hincks-Dellcrest Centre. A case file is also opened for clients attending the Developmental Clinic. In this case a referral form is completed, a file created and stored at the G.T. project site. Ninety such files were opened in 1996. The Toronto Public Health Department office houses nursing files which are started with the receipt of a Birth Registration Notice. Three-hundred and fifty-nine PHN files on G.T. families were opened in 1996. An ongoing challenge faced by the program is related to the successful integration of client information, which may potentially appear in files in all three locations. Since the project is a collaboration between a Mental Health and DPH organization, workers do not have easy access to information housed outside of the project site. The internal record keeping policies of both organizations, safety and confidentiality precautions, as well as space restrictions, make it impossible at this time to store all files at the project site. The G.T. Management Information System is therefore critical to the successful management of G.T. cases.

Opening a G.T. case file

When an RFA is completed it is given to the MIS co-ordinator who enters it into the G.T. data management system and then he sends a copy of the intake form to the Hincks, where a file is opened. If there is a direct referral where an RFA is not done, an intake form can be completed. For a Developmental Clinic file to be opened, a referral form is given to the G.T. Secretary who starts a file folder.

The on-going monitoring of clinical cases is carried out through bi-annual case reviews as well as by the presentation of case formulations during team meetings. It was suggested that a more discussion oriented format could occur in addition to the formal presentations. PHN participation in formulation presentations for cases they were also involved with was, at times, overlooked. Formulations are not a part of DPH procedures.

Workers feel case formulations and reviews are useful

It [case formulation] is helpful for me personally. I find it helps me pull my ideas together. When you are busy all the time it is helpful to think things through. I have presented every one of my Hincks cases because I find it helpful.

They give us a chance to review what has happened and plan the best next approach, and also close cases that have moved away.

According to Hincks-Dellcrest Centre accreditation requirements, all Mental Health Workers with the project are required to present case reviews on a bi-annual basis as a measure of quality assurance. During the last case review period, over 130 cases were presented by G.T. Hincks-Dellcrest Centre affiliated workers. While time consuming, all felt this process was a useful clinical and educational activity. Some questioned the necessity of having nurses present for case reviews, while others felt it was an important opportunity to learn about clinical interventions with families. Further discussion with staff about the procedure of case review and formulation and the involvement of DPH staff is merited.

***Case Management Activity #3*: To conduct case consultation as a multidisciplinary team on a weekly basis.**

Growing Together team meetings are held every Wednesday morning for three hours. Every other week the full G.T. team (i.e., Hincks-Dellcrest Centre and DPH members) come together. Weeks in between, Hincks-Dellcrest Centre affiliated workers meet.

The importance of these meetings, is that they are a vehicle to share Hincks-Dellcrest and DPH program and agency update information. They also provide opportunity for team members to network and consult about cases. This is particularly valuable in those situations where more than one worker is involved with a family. All interviewed workers had had the experience of being involved in a case for which there was more than one G.T. worker. According to MIS records, almost twenty percent of G.T. families receive services from more than one worker. Families identified as being at higher risk tend to be over represented in this group.

Workers learned about the involvement of their colleagues in a variety of ways. In most instances workers' involvement was initiated by the case manager or case worker. Under these circumstances each member's involvement in the case was clearly defined and discussed. There were other instances, however, when workers discovered the involvement of other G.T. workers by chance. The multi-service nature of the program makes it difficult to avoid such occurrences. Furthermore, clients themselves often feel uncertain about which community services are actually a part of the program. Workers could make greater use of the MIS prior to initiating contact with a family in order to determine other worker involvement. Through the MIS, workers can identify clients who have attended groups or received other support services such as advocacy, counselling/therapy interventions, or have attended the Developmental Clinic.

Cases with more than one worker

One time a client left a message on voicemail for someone else and I learned they had been a client for a long time. Now I try to make a habit of looking on the computer to see if they are already a client.

The family might tell me.. 'so and so visited'. It makes things awkward at the time. They see us as a unit, so I feel I should know if somebody contacted a family I am working with.

The Management Information System, however, cannot capture all aspects of worker contacts with families. Worker contact in the community is continuously expanding due to community development initiatives and worker outreach. Additionally, PHN case involvement is currently not documented at the project making it difficult to know when consultation should be occurring. Giving opportunity for workers to discuss their cases is of central importance for these reasons. Beyond these issues, cases with more than one worker may also give rise to questions about case management and case planning which can then be discussed at team meetings.

Case consultation

Case consultations [often] occurs informally or at my request, if there is a problem.

I tend to consult on the fly or by phone. I was away for a holiday and when I got back there was a message from a group leader telling me that a client of mine had got some bad news from the Developmental Clinic. That was helpful, and I could follow-up.

In addition to discussing shared cases during team meetings, workers consult by telephone, through memos, and in person. Workers commented that many consultations occurred informally. All felt this system was working well given the fact everyone’s time is limited.

6.2 Referral and Consultation

Referral of Growing Together clients to other G.T. services as well as to external community services ultimately encourages the appropriate use of services by families in St. Jamestown. Reviewed here are the activities of: 1) the referral of G.T. clients to outside services and the referral by outside services to the program, 2) the client referral process within the program, and 3) the provision of client and educational consultation to outside service providers (See Table 14).

Table 14
Procedure Sheet:
Referral and Consultation Component

Program Activities	Evaluation Questions	Data Collection Strategies
1. To refer G.T. clients to appropriate outside services as well as encourage referrals to the program.	1a. How many clients (adults and chidlren) are referred to outside services? Reasons? Rate of accepting outside referral? 1b. How many clients are referred to G.T. by outside services? (Characteristics of these families and the referring agencies). 1c. How do outside service providers perceive G.T. services?	1a. File reviews to determine rate of outside referral and characteristics of these clients. 1b. File review to determine number of clients referred by outside services. 1c. Interviews with selected staff of outside services about their perception of G.T. services.
2. To facilitate the internal referral of clients identified as having additional needs.	2. What proportion of G.T. clients are multiservice users? How have multiservice clients learnt about existing G.T. services? How do staff make internal referrals?	2a. MIS records on the number of clients who are multiservice users. 2b. Interviews with selected staff and clients about how clients are referred to or enter into other G.T. programs.
3. To consult with other community agencies or groups working with parents and provide client consultation concerning developmental behavioural and	3a. How many community agency education sessions have been conducted? 3b. How many consultations have been requested of	3. Interviews with involved staff about client consultation and education sessions provided to community services.

Sometimes consultation needs to be more structured

How does an individual case manager find out about what happened in the Developmental Clinic. Sometimes I will write a note to the clinicians but there could be a sheet that the Secretary gets saying these clinicians need to check these [Clinic] files.

Outside service providers appreciate the Developmental Clinic

Over the years we have very good reports about the Developmental Clinic. Two families in particular we have referred over there raved about the services... It changed their lives, both were concerned about autism. ... They got help with that... it has been a wonderful support.
Outside Service Provider

The program's welcoming atmosphere is beneficial

What's valuable is that they are [G.T. is] part of the community. It does not appear to clients as an institution, its very welcoming. ... The barriers our clients deal with are authoritarian kinds of atmospheres where they feel they are being talked down to. G.T. provides a more open discussion opportunity whether it's the psychologists, pediatrician, public health nurse, etc. [they are seeing]. So she [referred clients] feel more comfortable.
Outside Service Provider

***Referral and Consultation Activity #1*: To refer Growing Together clients to appropriate outside services, as well as encourage referrals to the G.T. program.**

According to MIS intake information, 33 clients were referred to G.T. by outside service providers in 1996. This number is likely an underestimate as four interviewed local service providers estimated they had referred a total of approximately fifty clients per year. As well, many of these clients may not have specified they were referred by another agency. Parents were referred to the program by parenting programs, ESL programs, day cares, PHNs, physicians, and child protection agencies for the services of: the Developmental Clinic, home visitors/therapists, advocacy services, groups, and community events. Most often mentioned by community service providers was the importance of those services provided by the Developmental Clinic. It was greatly appreciated that psychological, speech, medical, and health assessments could be easily and quickly accessed by families. Referred families included isolated, new immigrant families of young children, as well as high risk parents whose children had temporarily been taken into care by the child protection agencies.

Interviewed service providers felt clients were receptive to the relaxed and welcoming atmosphere of the program, and to the program's convenient location within the community. Ensuring people at the project represent the community's various ethnic groups was also considered important.

The number of clients referred by G.T. workers to outside services is difficult to determine as this statistic is not clearly documented by workers. Unfortunately, file reviews were not a good method for calculating referral and acceptance rates, since this information is not consistently present in case files. The Growing Together file review of clinical cases showed 14% of clients were referred to outside agencies, with approximately one-half accepting the referral. Developmental Clinic cases were more frequently referred to outside services, with 26 referrals being made for 19 children (21%). For other children required services were obtained within the G.T. program. DPH case files rarely showed evidence of outside referral because required services were obtained within G.T. Interviewed service providers perceived the referrals made by G.T. workers to their programs as being very appropriate.

Overall, Growing Together was seen as a valuable service to the St. Jamestown community. There were a few service providers, however, who noted the feedback provided by the program about referred clients was not sufficient at times. Improved communication between services, in both directions, was an identified need.

<u>Referral and Consultation Activity #2</u>: To facilitate the internal referral of clients identified as having additional needs.

Internal referrals

[The referral system] is adequate because of the relationships on the team. In terms of a more reflective process, I would like to have more chance to have case and clinical issues be discussed. For nitty-gritty discussion, there is never enough time.

I would like feedback from a referral I give. If I refer to a group, I would like to know if she showed up and if it worked out.

The internal referral process is well understood and relied upon by workers. Over 80% of GT clients participate in more than two programs, with the average client joining three programs, and ranging between 1 and 13. Internal referral of clients is done in a variety of ways, depending on the service to which the parent is being referred. The Developmental Clinic referral system, for example, requires the completion of a referral form. Group referral, may be done through telephone contact, verbal referral, in writing, or by asking clients to contact group leaders directly. The referral procedure needs of the Child Care service and the newer TLC[3] program need to be further clarified with team members.

While most workers felt that the overall referral of clients to other services within the program was operating well, some concerns were noted. By and large, their comments indicated a desire to increase worker communication and feedback about referred clients. It is often difficult to contact workers who are not on site daily because of being based elsewhere or due to part-time status. The question of whether a more formal referral system for all services would need to be further examined by the Co-Directors through discussion with affected team members. Finally, workers identified difficulties associated with staff shortages which may mean that occasionally clients have to be on waiting lists prior to participating in some components of the program.

***Referral and Consultation Activity #3*: To consult with other community agencies or groups working with parents and provide client consultation concerning developmental, behavioural, and parenting issues, as well as educational training.**

Client consultations are requested of Growing Together workers by community services. Seven of fifteen workers reported they had provided client consultation to child protection agencies, schools, day care centres, and children's mental health centres. Contributing toward the development of a comprehensive plan of care for children in the community, workers provide valuable input into children's needs in the areas of education, development, behavioural management, and safety and protection.

In addition to this work, four G.T. workers reported they had provided local community agencies, organizations, and professional conferences (N=9) with educational sessions on topics related to early intervention and prevention programs. Topics included, parenting, violence in the family, child health and safety, and home visiting.

Table 15
Procedure Sheet: Team Development, Training, and Supervision Component

Program Activities	Evaluation Questions	Date Collection Strategies
1. To provide staff supervision to those workers seeing moderate and high risk families and conducting community interventions.	1. How often do GT staff attend team or individual supervision meetings with Program co-ordinators?	1a. Interview clinical supervisor about superivision in team meetings, review meeting notes for amount of time cases are discussed. 1b. Interview selected staff about clinical supervision, manner in which it is received.
2. To offer adequate orientation, training and support to all staff/students/ volunteers. As well to mitigate against staff burn-out by encouraging team member's team involvement in other aspects of the program.	2a. How many educational sessions are provided at team meetings (topics, attendance, impact)? 2b. What is staff/student/volunteer's experience of orientation, training? 2b. How many aspects of the GT program are staff involved with? (How important is this?)	2a. Review of team meeting schedules to determine types and amount of education training sessions for staff. 2b. Interview selected staff, students, volunteers about manner in which education/training is provided.
3. To have a process for identifying and recruiting appropriate volunteers for GT service needs.	3a. How many volunteers are involved with GT? What are their characteristics, roles, contributions, etc. 3b. How are volunteers identified, recruited? How long do they usually remain?	3a/b. Interviews with GT management about number, backgrounds, roles of volunteers. 3b. Interviews with volunteers about their recruitment process, commitment, and general experience at GT.
4. To offer students an opportunity to learn first hand about community-based, early intervention programs, and offer staff an opportunity to supervise students.	4. How many students are supervised, by what staff. How do students and staff feel about the experience?	4a. Staff interviews about manner in which student supervision is carried out. 4b. Interviews with selected students about the manner in which they have been supervised.

6.3 Team Development, Training, and Supervision

Providing workers with support, supervision and training is key to program success. Considered in this section are the activities of: 1) providing workers with supervision, 2) worker, student, and volunteer orientation training and work experience, 3) the process of volunteer recruitment, and 4) training and supervising students (See Table 15).

Team Development, Training and Supervision Activity #1: To provide supervision to those workers seeing moderate and high risk families and conducting community interventions.

All Growing Together workers receive case supervision through weekly team meetings. In addition, Program Co-Directors are readily available for consultation around difficult cases. Individual supervision has been available to Mental Health Workers in need of additional guidance and support, as well as for those needing individual supervision in order to meet professional college requirements. Supervision on the project was experienced as being sufficient by most. Some, however, felt that a greater opportunity to discuss the specifics of difficult cases would be beneficial. Ways to facilitate more case consultation time during team meetings should be explored with workers.

The importance of team work in early intervention efforts

It was the continuous supervision, conferences, and team effort which helped relieve the stress of working in the CIDP [Clinical Infant Development Program]. In hallway discussions, as well as scheduled meetings, it was possible to absorb staff reactions against the participants, to acknowledge often heroic efforts, identify avoidance and helplessness, and to refuel energies so that staff could return to and persist in the intervention. It was crucial to take time to identify problems, to understand dynamics, and to determine next possible moves. ... At some stages, as much times was spent in supervision and support as in direct contacts with CIDP participants.
Wieder & Findikoglu, 1987, pp. 17-18.

Supervision is sufficient

If [I have] any concerns about the client or they need services or have special needs then I make an appointment with the [program] director. ... That is enough.

It is sufficient. Right now it is regular supervision. In team there's also supervision. There is also an open door policy, if I need anything I can phone or meet the Director.

I consider supervision when I speak to my supervisor. I can only think of two incidents when I have spoken to her about a client. It has been on my initiative. In those two cases it was sufficient.

More supervision would be beneficial

[I] consult with the Director when problems arise. Or any clinician, I get supervision of some sort. I would like more supervision because of controversies. It would help clarify what should be done [in difficult circumstances].

Orientation training

[I got] volunteer training. It was helpful, I learned about the program and how to help in the community.

I went to volunteer training. It was very helpful. Also staff meetings are a main source of training.

Mostly [I learned about the program] from other PHNs. It was organized in that I came with someone to the prenatal and Developmental Clinic. I had a meeting with one of the co-directors around how the program started and the services offered... I felt I had not pieced it all together... It took six months to get up to speed.

***Team Development, Training and Supervision Activity # 2**: To offer adequate orientation, training and support to all staff, students, and volunteers. As well, to mitigate against staff burnout by encouraging team member's involvement in other aspects of the program.*

Over the years, staff, students, and volunteer have received orientation training in differing degrees. When the project first began, workers engaged in extensive discussion with Program Directors about program design, operation, and early intervention initiatives in general. With time, new people joined the program and the need for initial training was addressed in one of two ways: 1) two to three day group training, and 2) an individual plan of introduction to program activities and policy. Variability in training has depended on the number of people entering the program at any given time, and the availability of people to conduct formal orientation sessions. Those who received formal orientation training over the course of a few days, were satisfied with their training. Those who learned about the program in a more active manner, such as by accompanying a senior staff person on home visits and by attending groups and team meetings, felt this hands on training to be important but were unclear about program operation for some time.

Educational, in-service training is provided at team meetings, usually one to two times a month. Interviewed workers rated this aspect of the program as extremely to very important. Educational training has been provided in the areas of: developmental delays; neurological development; psychiatric diagnosis and medication,

psychological disorders including borderline personality disorder; nutrition and breast feeding, various therapeutic approaches, domestic violence, and research initiatives. Additionally, various community service providers have visited the program to offer information on; immigration law, alcohol and drug rehabilitation services, infectious diseases, and sex education. Workers from different disciplines received information on topics to which they would not normally be exposed. It was also seen as important for ensuring workers have a similar knowledge base about the principles underlying program activities. Furthermore, workers felt their skills improved as a result of the sessions.

Importance of educational training

[The sessions provided] stuff we normally would not get. It gave me better skills. You handle the cases that seem odd or difficult because you have somewhere to refer them. Also, I do not think other nurses would look at these cases in the same light as we would. A lot of our in service [training] has gone a long way in helping us articulate the risk. ... But my learning needs are different now. At first it was extremely important. Now it is the nitty gritty things you need to know, like immigration questions. It is more client management versus program development areas [that I need to hear about].

As a team, it gives us a collective knowledge base. We have such a wide knowledge base because of the multidisciplinary nature of the team. So the psychology ones are less important or information [for me] but other areas [psychiatry, advocacy, PHN] are very informative.

It gives us a good foundation for doing our work and it gives us a good understanding of all the areas of the project that we may or may not be involved with.

Considering we come from health backgrounds, it is important for me to get information about child development, and how to work with families therapeutically. And learning about how one's psychological history impacts on parenting skills and present functioning. It helps you bring out a lot of issues.

Workers appreciate experiencing other aspects of the program

It gives you a more balanced perspective. Because I have mostly high risk cases, it provides a bit of balance.

You have a good understanding of how the whole project works [when you take part in other aspects of the program]. Then you are a stronger worker and you can make more informed referrals.

It affords me an overview of G.T. I cannot get when I work two days a week as a clinician. It also allows me to see my clients in an experientially distant manner, which is very helpful. You can get bogged down doing clinical work, especially when it is a lot of crisis work. Being on the research team allows you to see the organization of G.T. and you are better able to work with clients.

Work with the project involves considerable effort given the extensive needs of families. Mitigating against staff burn-out is a necessary priority. It is important to ensure staff are well supported, supervised, and, at times, have opportunity to engage in different, and perhaps, less demanding project activities. One half of the interviewed workers noted they were involved in activities outside their general job description and felt this to be an important opportunity for learning. Workers had become involved in: fund raising, attending community and agency meetings, preparing funding proposals, and participating as a G.T. Research Team member.

Some workers participated in activities outside their job descriptions because certain tasks required attention. These individuals used their time to assist with: designing and renovating the physical space, assembling and cleaning furniture, washing toys and dishes, providing office relief, and sorting through donated toys. Given the project's limited resources, workers pitch-in in an effort to meet the special demands placed upon a busy community facility.

***Team Development, Training and Supervision Activity #3*: To have a process for identifying and recruiting appropriate volunteers for G.T. service needs.**

As of July, 1998, thirty-one volunteers were involved with the Growing Together program. For the purpose of this study, six people were interviewed who were previously or currently volunteering with the project. Volunteers provide services to: Child Care services (N=10), the Computer Training project (N=2), the Community Kitchen (N=3), the Advisory Committee (N=4), the Saturday Morning Club (N=8), the Infant Monitoring System (N=2), a Tamil Speech Therapist, a Child Care Coordinator, and an ESL group leader. A number of the volunteers who work in the Community Kitchen program, Computer Training project, and Child Care facilities are members of the St. Jamestown community.

Interviewed volunteers were all women who were educated in fields related to their project activities. Most had a University degree. They learned about the project often by word of mouth or through media publications and pursued the notion of volunteering by speaking directly with one of the Program's Co-Directors, responsible for volunteer co-ordination.

These individuals had been volunteering with the program for as long as four years and as briefly as three months. Most spent at least one day per week providing services such as: home visiting/counselling, group facilitation, and child care.

How do volunteers hear about the program?

I got the name of the program Director from [a Hincks staff person]. And she and I met and I started volunteering.

I came to the prenatal group and from there I spoke to [the nurse] and she introduced me to it [the idea of volunteering].

I saw an article in the Saturday Globe. Then I made several calls to the program Director. Then I made a call to the Hincks and was connected with the volunteer co-ordinator. In the meantime, the Director called me and I attended a meeting.

My mother's colleague told us about G.T. and she gave me the Director's name, and I called her.

A friend of mine was doing an internship here [at G.T].

Why volunteer?

I was encouraged to volunteer with the program because I wanted to get experience with children and work on a team. ... I also liked the idea of it being a community project. ... My goals were to get some training with younger children, and to be involved in the program's development in the early stages.

I wanted to help the children and I like to play with the babies.

[I was interested in joining as a volunteer because of] the fact that it was Early Intervention and the population [being addressed] was of interest to me. I grew up in city housing, and wanted to help. [Also] the fact it was based on attachment theory [made it attractive]. [Finally], the fact that it was community oriented and unique in its approach ... it was perfect.

I thought I would be working directly with children I didn't want to work in a daycare like a babysitter, I wanted to monitor them, like I am doing now [with the Infant Monitoring System]. ... I am working with kids who come from a very different background then mine. And you realize there are problems in the world and lives different from your own. ... It has been a great learning experience.

I was looking for a place where I could be useful to ESL [clients]. I trained a couple of years earlier and volunteered out of school. When my friend said there was no ESL [at G.T.] I asked if people would like me to start a group. ... Young mothers are a logical group because they cannot take their kids to the regular ESL classes [if their children are under 3 years of age].

Their time contributed to the program as well as to the expansion of their own knowledge base and skills. A few were active volunteers with other projects as well.

The orientation training and supervision received by volunteers varied from person to person. While some reported receiving formal orientation to the program, others attended meetings or shadowed a colleague for a period of time. Individual supervision was generally not provided, which resulted in feelings of isolation and a lack of direction for a few. This experience may be compounded by the fact that volunteers do not regularly attend weekly team meetings. Due to time constraints faced by those who volunteer, however, attending team meetings is not always a viable option.

Documented within the MIS are the hours of volunteer service and days attended by these individuals. According to this data, over fifty percent of volunteers at the project have provided more than 20 hours of service, to a maximum of 200 hours. Student hours may at times be submitted, however, as volunteer hours. The differing roles of volunteers and students needs to be clarified with workers and this problem rectified.

***Team Development, Training, and Supervision Activity #4*: To offer students an opportunity to learn first hand about community-based, early intervention programs, and offer staff an opportunity to supervise students.**

Over the years, twenty-five to thirty students have participated in the G.T. program. Students participate in various aspects of the program, depending on their area of study and interest. At the time of this study, the project was providing training to seven students. They included: two psychology interns, a psychiatry resident, three undergraduate social work students, and high school co-operative students.

As part of this study, six students were interviewed who were currently in or had in the past completed a placement with the project. Placements ranged in length from four months to one year. Their areas of study included, psychology, early childhood education, and social work. The students were in the process of completing requirements for a professional diploma, Bachelor, Master, or Ph.D. degree.

The students had heard about the program through teachers, placement coordinators, and other students. Since previously placed students have had good experiences at G.T., the program is well respected by those referring students.

Students requested placement at the G.T. program in order to: receive clinical training with 'at risk' families, develop assessment skills, work with other professionals as part of a multidisciplinary team, experience community based work, understand

G.T. is known as a good placement for students

I heard about Growing Together through two different teachers at school. I went to talk about a placement. I wanted something more challenging than most of the placements other students were receiving. ... They [my teachers] heard great things about the program, and they had placed others students here before.
Social Service Worker Student

Why do students seek out placement at G.T.

I had interests in early intervention/prevention, working with new immigrants, families, diverse communities and cultures, community based programs, and the multidisciplinary team approach. The other thing that I had interest in was the joint project approach... the joint effort between the Hincks, and Public Health.
Early Childhood Education Student

I like the fact that it is a professional agency, but on the other hand it is also very warm. All the staff are friendly and compassionate and willing to train. ... Everything that my supervisor does is applicable to what I want to learn. ...
Social Service Worker Student

how to reach and serve multicultural families, and to learn about research. Students were seeking opportunity to apply theory learned through their programs to actual practice. In most cases, students became involved in more activities at the project than originally anticipated. Similar to the experiences of other staff and volunteers, orientation to the program was not equal for all students. While some had opportunity to attend formal training sessions, others received a more gradual introduction to the program, through team meetings for example.

All those interviewed felt their Growing Together placement was relevant to their field of study and that their personal and professional placement goals had been achieved. All six had received supervision which they also rated as appropriate and sufficient. Interviewed students had received supervision both through team participation and through individual meetings.

Students were supervised by the Hincks-Dellcrest Centre Co-Director and by senior staff, from both the Hincks-Dellcrest Centre and the DPH. Approximately one half of the interviewed workers had provided a student with supervision at some time. Many students are supervised by a number of different workers depending on the extent of their involvement. A student, interested in assisting with the Mother's Club, for example, would receive supervision around group facilitation from the senior group leader as well as from a primary staff supervisor. Workers who provided supervision services to students found the task both manageable and enjoyable.

Overall, students placement experiences were rated as very positive. In past years, a few students, remained involved as volunteers at the project even though their student placement had ended.

Students enjoy their placement experiences

It [my placement] gave me a chance to initiate my own learning and independence. It helped me build confidence too. ... My placement supervisor was a role model in my future aspirations. ...I learned so much. [My supervisor] made me feel comfortable in approaching her. She provided me with resources and research which was relevant to my experience in working with individual families.
Early Childhood Education Student

I am really enjoying [my experience at G.T] a lot. I find that it is a very supportive learning environment and that it is really unique opportunity for a student. The program is unique and yet in many ways it is going to be the new model in mental health service delivery. It is really important to get this kind of experience to develop these kinds of skills. One thing that has been striking is the strong commitment and enthusiasm by the staff and volunteers. As a student it is very inspirational. It is difficult to learn in other environments. It helps you get enthusiastic when you see others working in the area.
Ph.D. Psychology Intern

In team meetings they talk about different cases and you can learn a lot. ... I liked it, it was [a] positive [experience]. I was faced with unpredictable issues here, and I liked the opportunities such as co-facilitating a group.
Counselling Psychology Intern

6.4 Summary

Because of the large numbers of part-time staff, students and volunteers involved in Growing Together, as well as the partnership between Children's Mental Health, and Public Health team management and development and staff training and supervision presents a challenge. The "team" is constantly changing and both partner agencies have faced significant reorganizations and the development of new policies and procedures. As many as 53 staff, students and volunteers may be involved in the project at any one time. As well, the diverse needs of families means that the team is a complex interweaving of different languages, cultures, expertise and responsibilities. As well, both Co-Directors have a variety of other responsibilities beyond the management of the Growing Together program. However, efforts are continually made to respond to clinical and programmatic issues and to meet the needs of families in the best ways possible.

One way that has been particularly successful has been the utilization of the team meetings as an opportunity for training, case reviews and discussions and sharing of information about a particular family. The team meetings are also an opportunity for training, case reviews and discussions and sharing of information about a particular family. The team meeting is also used as a way to share relevant information from the partner agencies, and to discuss aspects of the program such as the Developmental Clinic, childcare groups and community development activities. Besides group supervision at team meetings, many staff, students and volunteers also receive individual

supervision on an ongoing basis, while others receive it on an "as needed" basis, often after hours and in an emergency. Case formulation and reviews are mandatory according to the Hincks-Dellcrest accreditation requirements and are also valuable tools to provide training and to share expertise about cases. Because of the complexity of the program, as outlined above, the involvement of cases across a variety of activities is at times challenging to record, as clients make their own choices about attendance at groups, community events, etc. Although, efforts are made to co-ordinate this through the MIS knowing the activities of each individual family is difficult and will continue to rely partially on discussions between staff on an ad-hoc basis. However, efforts to improve the co-ordination of information in the MIS will be undertaken.

VII Community Initiatives

The *Community Development* and *Program Promotion* initiatives of the Growing Together program are examined in this Chapter.

7.1 Community Development

Community Development activities are directed toward promoting in individuals a sense of personal support, competence, and commitment to their community. Community development strategies promote: the existing capacities of community members and the development of new skills, a sense of belonging and community ownership.

Community development activities compliment the other work being done at Growing Together by mobilizing community members and by encouraging their program participation. Firstly, according to the Ottawa Charter of Health Promotion, (1986), people cannot achieve their fullest potential unless they are able to take control of those things which determine their health. Secondly, community development often serves as an entry point to the program. Individuals may feel that the program's Community Kitchen group[16], for example, offers a safe introduction to the Growing Together program. Through the course of their participation, clients meet other Growing Together participants and staff. Their social network increases, and they become

What is community development

Community development is the process through which all members of a community gain an increase in the control over their lives as well as the life of their community by achieving equal access to participate in collective decisions about their needs and in the development and implementation of strategies which utilize their collective power to meet those needs.
City of Toronto Public Health Department, 1991, p.1

Strategies for population health

Health determinants required for human well-being include; personal and community safety, healthy child development, respect and tolerance for diversity, income adequacy, perception of personal control, a healthy and supportive social network, the opportunity to contribute meaningfully to one's community, absence of overcrowding, and conditions that enable and support people in making healthy choices.
Federal, Provincial, & Territorial Advisory Committee on Population Health for Meeting of the Ministers of Health, Halifax, Nova

[16] The *Community Kitchen* is now referred to as *Cooking Healthy Together.*

Table 16
Procedure Sheet:
Community Development Component

Program Activities	Evaluation Questions	Data Collection Strategies
1. To encourage a sense of belonging among St. Jamestown families of young children	1. How many community activities were planned and implemented by GT (Types of activities and community response)	1a. MIS, Community Development (CD) staff records on the types of community activities and number of people involved. 1b. Interviews with staff and selected clients regarding the community sense about how these activities were carried out.
2. To facilitate the community organizing and mobilizing for local and Government change	2 How many community actions for change have been undertaken by GT clients and staff? (i.e., safety meetings, safe play areas)	2. Interview with CD staff and personal records about time spent at community meetings and events etc.
3. To teach parents new skills and approaches to their lives and to encourage them to utilize current capacities	3. How many parents have taken part in self improvement groups or activities? (i.e., women's group, literacy programs, computer skills)	3. Interviews with group leaders about the number of parents involved in these activities/groups.
4. To support entrepreneurial activities of mothers in St. Jamestown (i.e., catering business, cookbook, cooperative day care, computer skills class)	4. How many women have been involved with business activities or gained job skills through GT? Characteristics of women? How has this process been for women?	4a. Interviews with involved staff and selected clients about the number of women involved in business/self improvement activities, types of activities, characteristics of women etc. 4b. What do women think about the manner in which these activities have been delivered/organized.

interested in participating in other aspects of the Growing Together program.

Workers involved in the facilitation of community development initiatives may also observe parent-child interactions or behaviour that result in clinical intervention. As well, community development activities provide a forum for Growing Together clients to work on clinical concerns, such as reducing social isolation, promoting self-esteem, and increasing one's personal sense of power and control. When parents feel less stressed and in control of their lives, they are more readily available to their children. To this end, the Growing Together program encourages parents to use and strengthen their own capacities, as well as develop new skills, and become involved in creating a safe and healthy community in which to live and raise their children. Community development together with Growing Together's other intervention activities, that is, health promotion, advocacy, and counselling/therapy all work to help community members enhance their individual, family and community lives.

The Community Development activities to be examined in this Chapter are: 1) encouraging a sense of belonging amongst community members, 2) facilitating community organizing for local and Government change, 3) teaching parents new skills and encouraging the use of their current capacities, and 4) encouraging business and entrepreneurial activities of mothers living in St. Jamestown (see Procedure Sheet, Table 16).

<u>Community Development Activity #1</u>: To encourage a sense of belonging among St. Jamestown families with young children.

A Community Development worker has been a part of the Growing Together project since September 1994. The goals of the Community Development worker have been to: encourage a sense of belonging amongst community members; encourage community ownership of the Growing Together program and its services; determine the needs of community members and promote their skills and capacities to meet their needs and enhance their lives; facilitate groups and meetings within Growing Together and the larger community; promote community involvement within and beyond Growing Together; and form partnerships with local community residents, organizations and businesses. This work is accomplished in four key ways: 1) through the facilitation of Growing Together support groups, 2) community organizing; 3) networking with community service providers and becoming personally involved with local planning committees, and: 4) organizing and coordinating large community events.

During 1996, six community events resulted in the participation of over 1000 community members. The events were organized by the Growing Together Community Development Worker, in cooperation with other project staff and community organizations. A list of 1996 events and the estimated number of participants in attendance at each event, appears in Table 17. Activities helped to encourage community involvement as well as educate adults about parenting and promote the

Table 17
Growing Together Community Events
(1996)

Community Events	Participants N
2nd Community Art Show – 78 artists & 3 community groups	200
‘Kids Count Day’	250
Bus Trip for Apple Picking	85
Growing Together ‘Open House’	100
Kick Off Day for ‘Hang Your Hopes on Kids’ Campaign	100
Growing Together ‘Christmas Party’	300

Workers agree, "Community events are the public face of Growing Together"

I think it brings the community together. When we had the BBQ the whole Rose Avenue [School], staff and children, came. It's nice to have that link. ... It makes you feel like a part of the community.

I still remember [the local politician's] face when she walked into Kids Count Day -- there were 250 people [there]. They came as families. ... I think they [community members] like the opportunity to interact amongst themselves and feel connected to Growing Together.

[Community events] really are the public face of Growing Together A lot of the other work we do tends to be private. I think it is extremely important.

[Community events] help to build the community and help them [members] feel not only part of Growing Together, but part of their own community.

G.T. program. Finally, these events provided opportunity for celebration and social gathering.

The St. Jamestown Community Art Show is a wonderful example of an annual celebration of the artistic talents of St. Jamestown residents of all ages. The art exhibit reflects the diversity of people living in St. Jamestown. This type of forum gives opportunity for ethnically diverse groups to mix when traditionally they would not. Those who attend get to know their neighbours and what their experiences have been, learn from each other, and develop a respect and understanding for their fellow community members. The Art Show has tripled in size since its first year to a current 130 artists. In the last two years there have been dance and music performances and the local school has become involved. Local press coverage and artists' booklets are meaningful components of the exhibit. Approximately 200 community members attended the event in 1996.

Interviewed workers commented that community events play a critical role in making the Growing Together program visible. Bringing both residents and local service people together is an important outcome of these gatherings.

Seven of the ten mothers interviewed for this study had attended at least one community event. Their comments, appearing opposite, capture the importance of bringing families together to socialize and have fun. In addition to enjoying the organized events, community members have played an increasingly important role in their planning and operation, and now, with the support of the community development worker and other staff, are largely responsible for the content and implementation of many events. Community ownership of these events, along with other actions for community improvement, is a primary objective of the G.T. program.

Families enjoy G.T. events

[G.T. events] are the only gatherings, that I have noticed in St. Jamestown, where people really come. I guess it's the only ones [events] offered here [in this community].
44 year old, Filipino Mother of 3 & 6 year olds.

The Christmas Party was excellent. My kids enjoyed it too... It's a good place to meet people. It gets you out of the house and it's good for the kids to be out. ... There was lots of food.
32 year old, Canadian Mother of 2, 5 & 9 year olds.

The Back to School BBQ was very nice. We saw many people from the school. It was like a picnic. ... It was really great.
36 year old, Tamil Mother of 2 & 5 year olds.

G.T. successfully collaborates with local service providers

The fact you see flowers growing on balconies is a direct result of Growing Together. ... The community work [is beneficial] -- flipping hot dogs [for a community BBQ] is important work. The different characteristics [backgrounds] of families makes it very difficult to offer families [appropriate community events], [but] some kids would just be at school and home if it was not for G.T. community events. It's important to organize things so people [from this community] can be together.
Local Community Worker

Every collaboration with G.T. has been very positive. They are very professional and clear about their goals and objectives. Every initiative has been worthwhile. .. Any time you have a large event and pull community members in, it gives people an opportunity to make some ties. They are all there for a common cause. It can branch out -- people meet each other and think, there are people in the community who value the same things I do. G.T. has played a leading role in our community with special events and bringing the community together.
Local Community Worker

[Collaborating around the Community Art Show] has been a wonderful experience. Last year we spent a lot of time looking at people's art pieces. It was a privilege to do that -- to hear them talk about what they do and how they learned [their art]. I felt moved by the pride they have in their community. ... I love that it [the Art Show] is so inclusive of everyone. It really fills a gap. People need to be artists, they need beauty.
Local Community Worker

Another positive effect of community events has been the strong sense of partnership established between Growing Together and local service providers. Collaboration around the planning and execution of community events facilitates greater investment and interest in the St. Jamestown community for all those involved, bringing the whole of the community together.

A difficulty associated with the organizing of these large events is the diversity of cultures and religious groups living in St. Jamestown, making it a challenge to offer activities that are of interest and appropriate for all families. Every event provides new information about how best to proceed in planning future gatherings. For example, although Growing Together staff and clients were anxious to use the new space at Growing Together for the 1996 Christmas party, the large community turn-out resulted in overcrowded facilities. Holding large events at the local community centre, since project space is limited, has helped to alleviate this situation. Regardless of these challenges, workers and clients felt that there were benefits in providing families with opportunities to meet and come together.

***Community Development Activity #2*: To facilitate community organizing and mobilizing for local and Government change.**

Traditionally, St. Jamestown has been a fragmented community. Much of the community development worker's time includes working to create partnerships and working relationships with the local schools, agencies, businesses, politicians and police to help in the building of a cleaner, safer, and family oriented neighbourhood and to avoid duplication of services. In partnership with community members, Growing Together workers facilitate and participate in community groups and committees that focus on identifying community needs, organizing for social and political action, and implementing improvement projects. Since the start of the G.T. project, eleven such initiatives have been undertaken. A list of key projects and involvement are provided in Table 18.

Working together to build a strong community

All the historic evidence indicates that significant community development takes place only when local community people are committed to investing themselves and their resources in the effort. This explains why communities are never built from the top down, or from the outside in. Clearly, however, valuable outside assistance can be provided to communities that are actively developing their own assets.
Kretzmann & McKnight, 1993, p.5.

Table 18
Initiatives to Identify Community Needs

St. Jamestown Safety Committee
St. Jamestown Community Garden
Food Access Project
St. Jamestown Community Art Show & Safety Fair
Kids Count Day
Kids Count Workshop Series
Friendship Club
Craft Club
Computer Skills Training Project
Weekly Employment Skills Sessions
Safety & Magic Show
Open House for Growing Together
Trip to Ontario Place
Trip to Allen's Garden
4 Christmas Parties
2 Parties for Community Garden
Walking School Bus

The Women's Community Group

The women decided that as parents of children living in St. Jamestown, they were most concerned with safety. They chose one park site that they were particularly concerned about and developed strategies to try to make it safer. This was a process because most of the women were not used to speaking out and having their concerns and opinions heard. Nor were they familiar with the process of finding solutions at the community level. They went on to send letters to the building management and had a meeting with management, security guards, police and a representative from a local politician's office. Some of their suggestions were implemented by management. The women over time, learned about participating in community meetings, taking minutes, setting agendas, co-chairing and chairing meetings. Their concerns and ideas were also incorporated into a large community safety committee where group members were creating strategies to improve community safety.
Community Development Summary, 1997

A good example of a project which Growing Together women organized to create change in the community, is the *Women's Community Group* which arose out of the desire of women who completed the community kitchen program to continue to meet. Seven mothers met bi-monthly over the course of a two year period to discuss and address concerns that they had as parents living in St. Jamestown. The group was facilitated by Community Development workers from G.T. and the Toronto Public Health Department. Their projects included: The Good Food Box Program, creating a monthly calendar for Growing Together's activities, working to create a safer park area for children, coordinating their activities with the larger St. Jamestown Safety Committee and working with children in the community to create a community garden. As part of their strategies, the members learned to write letters of support, helped formulate and implement a successful funding proposal for resources to increase access to food for all community members, coordinated and hosted meetings with local police, politicians and property managers, attended training programs, learned to advocate for and access resources and formed working relationships with other community members and agencies. An increased sense of confidence has allowed these women to continually move towards creating a healthier life for themselves, their families, and community.

G.T. staff involvement with the *St. Jamestown Network* is another approach to organizing for community change. *Network* members, made up of representatives from local community services, meet for two hours every second month in order to share information and advocate on behalf of the

community. Recently, the group prepared and submitted a letter to Government officials outlining concerns related to the closing of the Wellesley Hospital which serves the St. Jamestown community.

Other projects have been more long-term, collaborative efforts. The *St. Jamestown Safety Committee*, for example, was established in 1995 by two local councillors to ensure follow-up of safety audits carried out in several of the apartment buildings. To respond to community members' continued concerns about the safety and cleanliness of St. Jamestown, the St. Jamestown Safety Committee was revived by Growing Together's and Toronto Public Health Department's community development workers. The Committee is proactive, task oriented, inclusive and representative of all community members and uses innovative strategies to build a safer community. The Committee is a collaboration of community members, business owners and property managers and is supported by local police, politicians and institutions. Workers and families from Growing Together and Growing Together's Women's Community Group are active members of this Committee. Growing Together's community development worker and a community resident co-chair the Committee.

To reintroduce the Safety Committee to the community, a Safety Fair Day was held in collaboration with the 4th Annual Art Show. Forty organizations that offer services to promote safety in St. Jamestown hosted information tables. Feedback from participants and guests were very favourable; they said it was great to be able to talk

The Safety Committee

We are working with community members and agencies to find out how people want to make a safer community. I would consider the community garden to be a part of the safety initiative because people working in the garden show they are taking pride [in the community]. Last year the garden was trashed -- plants were stolen. This year people were respectful of other people's property. They appreciate the effort and were proud that so many children were involved.
Community Development Worker

to service providers, learn what was happening in their community, and meet other community members. Service providers also remarked that it was great to be able to meet and network with other community workers. Two hundred community members attended this event.

Other community events have included a Sing-A-Long and Magic Show to promote the theme of community safety and provide educational entertainment to 150 community children and their families. A lunch was catered by Origins, the catering group started by members of Growing Together's Women's Community Group. As well, a "Back To School BBQ" was held for 150 community children and parents as part of the initiative to make food accessible to all community members.

Part of the *Safety Committee* initiative, the *Community Garden* project helps make the neighbourhood an attractive place for children and families to play and live. Planting flowers outside the local school and offering flower boxes for the balconies of local high-rise tenants, provides opportunity for families to show pride in their homes. In its second year, this program provided 150 families with the opportunity to beautify their balconies and in all, approximately 800 flowers were planted around the neighbourhood.

Also addressing the issue of safety is the *Prevention of Violence Against Women In St. Jamestown Project.* This one year *Project* was funded by the Ontario Women's Directorate and Wellesley Central Hospital. Growing Together, in partnership with five area agencies, worked to

reduce family violence in the community. A G.T. worker is involved in providing and coordinating educational workshops about family violence, conflict resolution, and safety, to women, school children, as well as local service providers.

While all of these initiatives are closely linked to Growing Together's objective of promoting the well-being and health of St. Jamestown families, the relationship between certain community activities and the program's mandate is not always apparent to community members and service providers. Ensuring collaborative planning takes place and includes as many local service providers and community members as possible is vital for the continued success of community development initiatives.

The challenge of integrating community development work

Some [G.T] activities are perceived as being outside the mandated activities of Growing Together. Like the Safety Committee, there is a question about what this has got to do with the G.T. mandate. [Some] people in the community feel this is their job and feel threatened.
Local Community Worker

***Community Development Activity #3*: To teach parents new skills and approaches to their lives and encourage utilization of their current capacities.**

Skills training groups at Growing Together enhance parents' sense of self-confidence and competence, help them to become more employable, and encourage their seeking out and/or advocating for needed neighbourhood services. Growing Together parents gain new skills by participating in: the English Club, Computer Club, and Cooking Healthy Together. A few local service providers highlighted the positive impact the G.T. program has had, in general, on women's confidence and self-esteem. Workers perceived women who attend the program as community leaders who go on to

Community members become leaders

I have found clients who join G.T. have got self confidence [as a result of the program]. They become community leaders, and if they know of someone who is pregnant they bring the woman to a group like the Prenatal Group.
Local Community Worker

The [program's] approach to family and community is fabulous. The support they give to this community cannot be measured. I have seen women in this community become [more confident] as a result of their participation [with G.T].
Local Community Worker

promote Growing Together's services in their community.

Women learn new skills

We do not have a chance to speak English [in our everyday lives]. When we come [to the English Club] we get a chance to speak English. [We] learn vocabulary, sometimes we write something and she [the group leader] corrects it for us and she gives notes on how to improve our writing skills and how to prepare for an interview.
36 years old, Tamil Mother of 2 & 5 year old.

Before I did not know about computers. I like this group. I bring my baby at the same time I learn computers. Everybody in the group is very helpful and friendly.
32 year old, Tamil Mother of 12 month old.

In the Community Kitchen we learned about other foods from different cultures. They [group leaders] were well organized, but it [the group] was too short.
32 year old, Tamil Mother of 1 year old.

We came two or three times to the Craft Group. I liked it. Then the teacher changed and the classes stopped. I would like to have the same teacher all the time. I want to learn how to make toys for my baby.
32 year old, Tamil Mother of 1 year old.

The *English Club* was attended by 15 women in 1996. The group teaches mothers, who are primarily Tamil speaking, about Canadian culture while providing ESL training. In some instances women cannot attend regular ESL classes because their infant is still less than two years of age and is therefore too young to be cared for by ESL daycare services. Others prefer the *English Club*'s flexible attendance schedule. A Beginners Class for women who speak virtually no English encourages them to become more confident in speaking English in everyday situations, such as when they go to the bank or grocery store. Women who possess better English speaking skills attend the Advanced program and continue to expand their skills in writing and speaking English. Professional and academic needs are often addressed in this group. Women may learn by conducting mock interviews or spend time preparing for language examinations. A woman who attended the English Club for over one year, felt the Group offered her a valuable opportunity to improve her English skills.

The Community Kitchen, which began in 1995, was the first G.T. community development initiative. Between 1995 and 1998, fifty-six people have participated. The participants are primarily Tamil and Filipino women. The format of the group has changed since it began and currently, it is held once a week for 8 weeks. Because of the emphasis on small group process, the kitchen has worked well with these small numbers. There have been changes to the program over time to better fit the needs of the participants. The purpose of the group

is to learn new cooking skills, cook healthier meals for participants and their family, exchange recipes with members from other cultural groups, learn and exchange budgeting tips and increase social networks. It also is a forum for parents to bring ongoing parenting issues such as feeding and parent-child separation questions. Parents have the opportunity to learn and share from each other, as well as from G.T. staff. The greatest benefit noted by participants was the improvement in their social networks.

Three participants have gone on to take training courses and now co-facilitate the program with a public health nurse. Community member facilitators actively outreach to bring in new members. Group members also rotate child care responsibilities during the program.

The *Computer Skills Training Project*, which includes both a Beginner and Advanced Class, has been operating for approximately one year. Women attending the Community Kitchen originally requested that G.T. provide this service. To date, a total of 38 women have completed the program. One male is currently enrolled in the Advanced Class. Seventy-two people are on the waiting list. The women are largely new to the country, and have not had much opportunity to learn about computers in their homelands. The goal of the *Computer Skills Training Project* is to teach members of the community basic computer skills to: improve their employability in the Canadian marketplace; provide another channel of communication for themselves and with their children who learn computers in school; and encourage graduates to take outside advanced

computer courses, continue their formal education, or seek employment opportunities. An important feature of this Project is that graduates or women too advanced for the skills training, are trained as volunteers by the coordinator to co-facilitate classes and lead tutorials.

In addition to these skills training groups, a *Craft Group* was offered last year. This group was run by a volunteer from outside Growing Together. It was popular and was attended by 35 women over the course of the Group. Unfortunately the volunteer was unable to continue and although efforts were made by residents to keep the group running, they were not successful. Due to a lack of funding for paying an instructor, the group was not able to recommence. Participants who attended this group were disappointed that the group had to end and have requested that it be offered again as soon as possible.

<u>Community Development Activity #4</u>: To encourage and support the business and entrepreneurial activities of mothers in St. Jamestown.

An important task of community development work has been to continually determine and respond to the needs of community members. By listening to G.T. clients, groups and programs have been developed that are in keeping with the interests and needs of program clients. As previously mentioned, the *Computer Skills Training Project* was developed out of women's expressed desire to learn computer skills. These skills will ultimately assist in making community members more employable. Obtaining job skills are a key concern for parents who are often unemployed, underemployed, and/or financially overburdened.

Building business skills

[Providing clients with business skills] were [initiatives that were] all initiated in response to community members' needs. But we can only take them so far and then they have to go out on their own if they want to go further. We gave them a good start and a supportive environment.
Community Development Worker

Five women who were originally a part of the *Women's Community Group,* when asked about future directions for the group, decided that what was of most concern to them was their financial predicament and their need to earn money. They decided that their most marketable asset was their culturally diverse cooking skills. With the help of professional women from the private sector, the women worked to build a food business. Two of the women went on to form a catering partnership, called “Origins” and they catered to the Hincks-Dellcrest Centre and, to a lesser extent, others in the community. On occasion they were able to employ former participants of the Women’s Community Group and other residents in St. Jamestown. One of the partners has since found full-time employment and other original members have found work or returned to school. One of the

Earning money is key

Some of the members of the Women's Community Group decided that they needed to earn money. They decided that their most marketable asset was their cooking. They were set up with volunteers who had experience in the cooking field and in small business. They worked extremely well together and the women from St. Jamestown learned a lot and still consult with the volunteers. They started catering for the Hincks Centre's special dinners in August 1966 and have been catering there on a regular basis ever since. They have catered for private parties, the local school and community events.

women commented on her experience. Her words appear opposite.

Projects in the developmental stage include a community kitchen cookbook started by participants of the community kitchen. Another community development initiative, the Growing Together newsletter, will use community development strategies and will be a joint effort between the Community Development worker, and workers and members of the English Club and the Computer Skills Training Project. A steering committee consisting of workers and residents will determine the focus and content of the newsletter. Another initiative is the Mentorship Project. Its purpose is to link women in St. Jamestown who have professional training with a professional with similar skills currently working in the Canadian marketplace. The mentors will provide helpful information and help open up opportunities for women seeking employment or requiring Canadian certification. The first step of this project will be to examine what exists in this field already and determine whether such a project is feasible or merely a duplication of existing services. The catering business is an example of a mentoring relationship that worked well.

Starting a catering business

I have gained confidence in talking to people. My cooking skills were not great [before], but I have learned other recipes. ... I feel good about it. The time I spent here, coming to the community kitchen, was productive. I am earning something from it. And we hope it will be even more productive in the future. ...My organizational skills have improved [since we started the business].
44 year old, Filipino Mother of 3 & 6 year olds.

7.2 Program Promotion

***Program Promotion Activity #1:* To encourage St. Jamestown families use of G.T. programs through outreach and education in the community to both expand client use of services and bring in new clients.**

A primary method of informing both parents and professionals about the project is through G.T. pamphlet distribution. Separate pamphlets for clients and service providers have been developed and the client version has been translated into Tamil. In 1996, 850 G.T. pamphlets were printed and distributed. G.T. calendars outlining the events for each month are also prepared, with approximately 50 being distributed monthly. Most printed material is personally handed-out by the workers themselves during home visits. Clients may also pick up these materials at the main office. Also, PHNs and the Mental Health workers ensure pamphlets, calendars, and/or group flyers are mailed to mothers who agree to a mailing at the time of initial telephone contact as well as to those who cannot be reached by telephone.

Community service providers have received details about the program through personal contact with G.T. workers. Workers indicated that part of their time was dedicated toward providing information about the program to local services and officials which included: hospitals, schools, a Community Centre, Police and Fire Departments, Metro City Councillors, Lawyers, CAS and CCAS, an ESL program, Day Care Centres, Parenting Centres, Church Groups, a Networking Group, and other

Workers use pamphlets and calendars to promote the program

If I [am unable] to do a home visit, I will drop a pamphlet in the mailbox, or if I cannot reach them [by phone].

The calendars have been helpful in the Developmental Clinic -- to get people connected [to the program].

Any kind of information about upcoming events we would distribute at our Group. I try to carry them [calendars] with me.

At the time of the RFA [Risk Factor Assessment] I give Tamil pamphlets and the [monthly] calendars [of events].

local services such as grocery stores and banks. General information sessions, which ranged from 15 minutes to a few hours in length, have also been provided to local agencies particularly those who may wish to refer families to the program.

In an effort to ensure clients are closely involved with the development and operation of the program, clients opinions and experiences within the program are frequently solicited. Clients are also encouraged to volunteer their time and participate in the program. Currently, some G.T. participants also volunteer in programs such as: Group Co-instructors/facilitators, Child Care workers with the Infant Monitoring System, and as Advisory Board members.

***Program Promotion Activity #2*: To respond to outside services interested in learning more about G.T. and community based early intervention programs.**

The Growing Together program is a unique project and, as a result, there has been considerable interest in the operation of the program. A total of 87 requests for information about G.T. and related research have been received since the year 1997. Requests were made by a variety of professionals located across Canada and the United States. Professionals requesting information included those employed by a: Community Health or Resource Centre; Health Council; University or College; Division of the Ministry of Health or Social Services; Child Early Intervention Projects, Public Health Units, Youth and Parenting Service; Religious Groups; Early Intervention and Prevention Projects; and the Media. In the majority of cases, those contacting the project were interested in general information about the program. A standard G.T. information package was mailed to these individuals by the program's Secretary. Others were specifically interested in related materials, such as documents on *Home Visiting* and *Staying on Track Project* prepared by Dr. Sarah Landy. Answering phone calls and providing information can be time consuming, especially during busy times of the year. The development of a publicity package has been helpful.

G.T. also hosts a number of tours and guest visits in the course of a year. Representatives from Ministries of Health and Social Services, Foundation Representatives, Community Groups, and individual workers from other cities and other

G.T. sites, have all gained valuable knowledge by observing the operation of the program. Response to outside interests must be carefully weighed against the concern of ensuring privacy and respect for those parents and children attending the program.

7.3 Summary

The community initiatives outlined in this chapter, not only complement the other work being carried out at Growing Together, but also directly provide valuable experiences for parents. These experiences help to reduce social isolation as well as increase parents' self-esteem and sense of power and control over their lives.

The St. Jamestown area presents a number of challenges such as communicating and networking in what has been a fragmented and culturally diverse community. However, there have been significant gains and very noticeable growth both in the skills of individual parents and families as well as in the cohesiveness of the community and in the acceptance of G.T. events and initiatives.

Community development is part of a continuum through which community members move. Entering at a point of personal comfort parents become involved in certain activities and gradually move on to other levels of the program. Parents work together to learn new skills, exchange ideas and expertise and create better lives for themselves. A number of Growing Together parents have been involved in several skills groups including the Community Kitchen, Computer Skills training sessions and English Classes. Perhaps one of the most impressive areas of growth has been the expanding interest in events which have been organized through the program. What is even more important has been the increasing role played by Growing Together parents in the planning, implementation and operation of both the skills groups and these community events. In fact, in

many instances community residents are largely responsible for coordinating events and work along side the Community Development worker, and other staff.

Along the community development continuum, coalition building and advocacy has become a major focus. This includes working to create partnerships and working relationships with the local schools, other agencies, businesses, politicians and police. Relationships have been formed with local politicians who have worked with the *St. Jamestown Safety Committee* to support initiatives identified by local residents. For some residents, moving along this continuum presents many barriers, such as the practical difficulties of attending meetings with children and scheduling initiatives at times that meet the needs of mothers. Nevertheless, a number of successes are apparent and many parents are learning to access resources, and feel confident enough to sit on Growing Together's Advisory Board. Community members have developed a significant sense of belonging, ownership, and responsibility for the Growing Together project and the larger St. Jamestown community.

VIII Research and Information Management

Reviewed in Chapter VIII are the *Management Information System* and *Research* component areas of the G.T. program. The Management Information System (MIS) is a computer based system that organizes details about service provision to G.T. families, and serves as well, as a clinical tracking mechanism. Program research, on the other hand, has been undertaken at G.T. to empirically study the impact of the G.T. program on children and their families.

8.1 The Management Information System

The general goal of the G.T. Management Information System is to provide a systematic way to accumulate program service information. This is accomplished through the creation and maintenance of a Management Information database System consisting of a Master Client Profile data set, and seven additional data sets that cover the breadth of the work carried out at the project.

Two activities of the Management Information System are examined here: 1) the collection and processing of Risk Factor Assessment (RFA) information, and 2) the maintenance of a complete MIS computer database, that covers all aspects of program operation (See Table 19).

Table 19
Procedure Sheet: Management Information System Component

Program Activities	Evaluation Question	Indicators/ Measures/ Data Collection Strategies
1. To collect and organize information concerning risk for families during the post period	1a. Are RFAs thoroughly completed when submitted for data input? 1b. How do GT staff use the existing RFA form? Is it being consistently administered? Do questions seem relevant and sensitive? 1c. How helpful do GT workers perceive the RFA for both clinical and research purposes? What are the benefits and problems associated with the RFA?	1a. Patterns of missing data on the RFA will be searched for in the MIS. 1b. Interviews with selected staff about staff administration and use of the RFA. 1c. Interviews with selected staff and the research co-ordinator about the benefits and problems associated with the existing RFA.
2. To maintain a complete informative Management Information System computer database on all aspects of the program.	2a. What is the organization of the Management Information System and does it cover all program components? How useful is the system to staff? 2b. How readily can the service use patterns of GT clients be tracked over components and time (Groups	2a. Interviews with MIS coordinator and selected staff to determine usefulness and gaps in the existing Management Information System. 2b. Use of existing database to attempt to track the activities of randomly selected clients, with road blocks being identified.

Management Information Activity #1: To collect and organize information concerning risk for infants/children during the postnatal period.

One hundred and six Risk Factor Assessments (RFA) were completed by G.T. workers in the year 1996. Since the start of the project, five years ago, 535 RFA interviews have been successfully conducted and entered into the G.T. Management Information System.

Workers feel the RFA is a useful clinical tool

It [the RFA] is very helpful to get an idea of how [a] parent is coping, how they see their infant, how strong their support system is, and their social history .. so we can relate it to their present coping and what their stresses are and [the family's] level of risk.

It gives me a lot of information. Because I have the framework of the G.T. program I can do something with the issue or problem identified. If I were [working] somewhere else I would not ask the question because I could not offer them anything [services]. I have been in situations where I ask a question and the client breaks down, so it's taught me people hide their stuff really well, and if you ask the question in a non-judgemental way people will divulge if they feel you are going to help. So it makes sense to ask the question when we can help. You are not opening wounds you cannot address. It is satisfying as a nurse to do a good job.

Things come out that might not come out in a regular home visit. It [the RFA] brings out things for discussion. Like unresolved issues from way back when in their primary family. By talking about it they have a chance to resolve it.

Some of the workers interviewed indicated they do not complete RFAs or do home visits because of their specialized roles. Staff in the areas of Intake, Advocacy, Community Development, and Child Care do not complete home visits or RFA interviews. The remaining workers interviewed, who did complete Risk Factor Assessments with clients, all indicated that the RFA measure provides valuable clinical information about infant health and development and parent functioning. Their comments, some of which appear opposite, emphasize the value of interviewing parents about their own and their child's well-being. RFA questions allow workers to delve into a family's health in a complete, organized, and consistent manner. Furthermore, having resources and services readily available for any families identified as being in need of assistance, makes the task of interviewing relevant and meaningful for workers. Asking direct questions results in issues and needs being expressed by parents. As one G.T. worker aptly noted, she would not be comfortable asking the questions if she were not able to offer immediate services to those requiring them. Otherwise, one is

simply opening wounds without taking responsibility for addressing the necessary healing process.

Most workers administer the RFA by completing some interview questions at the time of the home visit, as well as filling in answers afterwards. At times, this choice may depend on the client's demonstrated anxiety around being asked questions. Telling parents that the questions are asked of everyone who receives a visit is a helpful strategy for reducing the uneasiness of clients. It was felt by some that items could be re-ordered in an effort to gradually develop toward more personal questions and improve the sensitivity of the interview. Questions felt to be less comfortable for clients were items addressing, alcohol and drug use, criminal activity, cult affiliation, and baby's attractiveness. Review of RFA data entered into the Management Information System indicates the most frequently missed pieces of information on the RFA tend to be: involvement in criminal activities, drug and/or alcohol use, length of baby at birth and at the time of the home visit, and the physical tone of the baby.

Workers talk about administering the RFA interview

I talk up front [with clients] about asking them questions and then administer it [the RFA]. If I learn information [through conversation], I fill it in. ... I interpret the questions [on the RFA] as best as I can for the client. I do not read the questions verbatim, and I explain the rationale for asking some of the questions.

For those who are anxious, it sometimes gives [the process] legitimacy to take out [the RFA] and fill in [the questions].

Some clients get surprised about certain issues being asked. But I explain the questions are asked of everyone. Some clients are offended when I ask if they drink or if they have been involved in criminal activities. I explain, so they understand.

Some questions [are more difficult for some clients]. For example, [the question] 'is your baby attractive?' Some mothers will just smile because in some cultures they do not like to say this -- to protect [the child] from 'evil's eye.'

Workers noted minor problems associated with the RFA

I am not always sure they [clients] give me the right information.

I think it [the RFA] gives you a base line from which to work from. It gives you an idea of potential risk. But it is limited because it [the family's situation] could change or they may not tell me things.

It may be useful [clinically], but it needs to be refined [for research purposes]. ... The interviewer who is interviewing the client uses their own discretion as to how they interpret risk. This creates a problem when we look at the number of risk factors.

I usually write a little summary on the page indicating level of risk. If we are only putting into the computer those multiple choice items, then that is a problem. ... I think the list does not capture all the risk, maybe it is just the wording that needs to be changed.

Problems associated with the RFA, as identified by workers, were: the absence of questions related to certain health risks, the difficulty of obtaining complete and accurate information from clients, and issues related to the checklist system which appears at the end of the interview, designed to determine the client's 'level of risk'. The latter was the most frequently mentioned.

An identified problem related to RFA administration was the discovery that, for some, there is no distinction between the use of the RFA for clinical versus research purposes. This confusion has resulted in RFAs being destroyed when clients fail to give consent for G.T. research participation. Procedure policy addressing this issue would need to be clarified with workers.

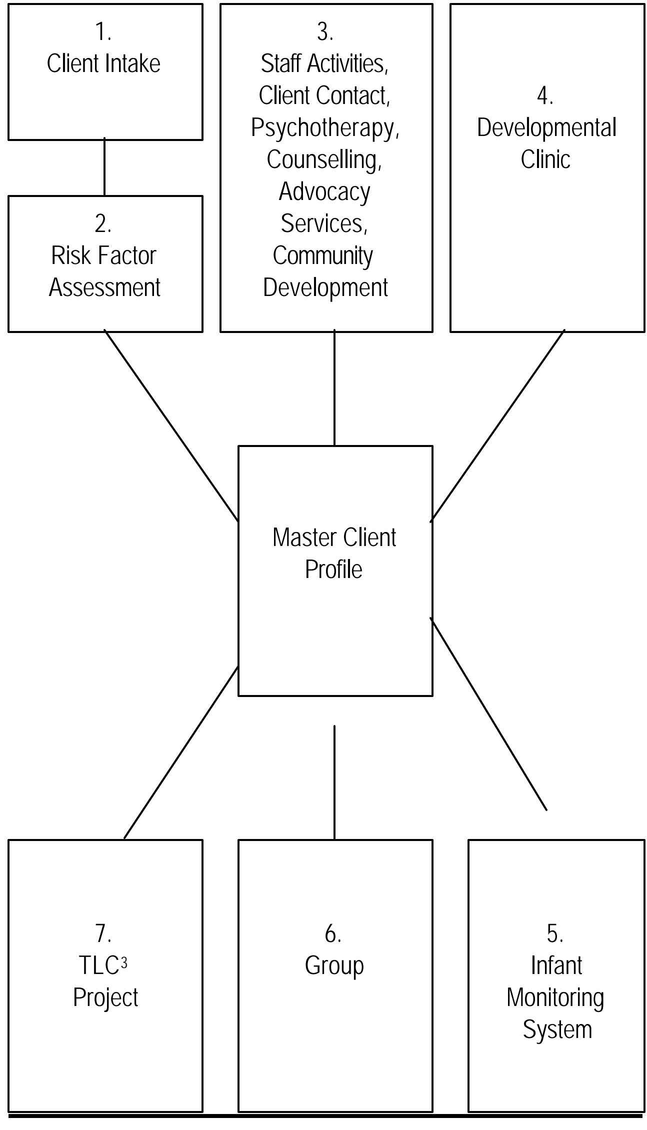
The RFA as a research measure

[RFA questions] help you know the nature of the population you are dealing with.

We can justify [through its use] that we are working in a high risk neighbourhood .. like how many families are moderate risk and so on.

It is a measuring tool to see who is high risk and not. You might not pick this up just by home visiting. Then you can see how many high risk cases there are.

Figure 32
Structure of the GT Management Information System Database



Managment Information Activity #2: To maintain a complete and informative computer database on all aspects of the program.

The Growing Together *Management Information System (MIS)* is an interactive database. A major advantage of the *System* is that it allows for the tracking of G.T. families and their service use patterns. Growing Together clients enter the program in different ways and participate in an array of services, therefore, tracking their participation requires the integration of information from various data sets. The MIS database documents seven client entry and service areas: 1) Client Intake, 2) Risk Factor Assessment (RFA), 3) Staff Activities and Client, Contact 4) Developmental Clinic, 5) Infant Monitoring System, 6) Groups, and 7) TLC^3 Project. In addition, a 'Master Client Profile' data set integrates these data, providing a summary of client service and demographic information. See Figure 32 for an overview of the MIS structure.

Information from the majority of these data sets were analyzed for the purpose of this Report. For the most part, the *System* provided an accurate and thorough picture of the program's daily operation. Still, no system is without problem areas. Noted difficulties in the completeness and accuracy of the MIS were as follows. (Recommendations for improving the System appear in Chapter IX).

It was not always possible to determine, through the *Client Intake* data set, how a client initially entered the program. That is, whether a family came to the program through the Birth Notice referral route, self referral, or outside agency referral route. As well,

variations in intake procedures, when translation services were needed, resulted in data on Tamil speaking families being inconsistently entered into the System.

The *Staff Activities and Client Contact* data set was limited because of the information collected on the *Individual Intervention Statistics* sheet, which is completed monthly by G.T. Infant Mental Health Workers. The form does not accurately capture the vast array of work done by all G.T. workers. Documentation needs to include activities of those who have specialized roles, such as the Community Development Worker, Advocacy Worker and program Psychiatrist.

The *Developmental Clinic* data set includes information about client visits to the clinic, attendance, as well as developmental assessment scores (e.g., the Developmental Inventory for Screening Children, DISC). Information on the reason for initial referral to the clinic, identified concerns, as well as case outcome and recommendations, was not available through the MIS. Since the start of the project, 191 DISC assessments have been carried out with 153 children. Children's scores on the Inventory's eight dimensions have been successfully entered into the MIS, with probable and possible delays being noted. According to these data, 113 children were identified with delays.

The *Infant Monitoring System (IMS)* data set is currently being extended to include information about the intervention undertaken with child participants. As well, the outcome of IMS cases referred on to the Developmental Clinic for follow-

up will be available through a linking of the two data sets.

Overall, the MIS database covers all aspects of program operation, with the exception of a few areas. Referral and use of Respite Care Services is not documented in the Management Information System. As well, service use patterns of the G.T. Child Care facility were not documented through the MIS at the time of this study. Father's participation in the program is also not recorded. While a few fathers have attended the *When Baby Comes Home Group* and the *H.E.A.R Group* over the years, their participation is not entered into the client database since mother is usually the primary client.

A major gap in the System is in the area of *Staff Activities and Client Contact.* To date, it is not possible to determine through the MIS the number of parents and children receiving therapeutic interventions or the types of therapeutic interventions provided. It is also not possible to know which cases PHNs are involved with since their case involvement and activities are not documented at the project. PHNs and Infant Mental Health Workers have two different case filing systems for documenting work with the same family. Identifying, through the MIS, all G.T. workers involved with a case is not possible as a result.

The majority of workers rated the Management Information System as 'somewhat' to 'very' useful. The ability to identify the service use patterns of clients was most often noted as their reason for

using the system. The service use patterns of clients can be easily tracked through the various services.

While the benefits of the MIS are apparent, there were some G.T. workers who did not know its purpose or how to access the information. Furthermore, none of the workers mentioned having used the system personally. Instead, they had referred their questions to the MIS coordinator.

Usefulness of the Management Information System to workers

I feel it [the MIS] is a good way of keeping all the data. It would be useful to know about a client -- if you wanted an update.

I went to the MIS co-ordinator once when we only had a mother's first name for the Developmental Clinic and he found the person on the system.

I do not really use it much. If I need to find out if a client is enrolled in the Developmental Clinic, for example, I might look somebody up. Sometimes I find it frustrating to find someone because a name is misspelled.

8.2 Program Research

Program research conducted at G.T. consists of collecting information at the time the Risk Factor Assessment is completed and, whenever possible, ongoing monitoring of the development of children through the Infant Monitoring System and the Developmental Clinic is provided. See Table 20 for an overview of the program activities involved under the research component area.

Table 20
Procedure Sheet: Research Component

Program Activities	Evaluation Question	Indicators/ Measures/ Data Collection Strategies
1. To inform parents about the opportunity to participate in GT research during the initial home visit.	1a. How many clients consent to participate in the research? (What are the characteristics of these clients?) 1b. How do staff explain the research component to clients and how comfortable do they feel in doing so?	1a. MIS data will provide the number of research consent forms completed, (RFA matched for their characteristics. 1b. Interviews with staff about the research component and the informed consent provided to clients.
2. To administer and collect information with moderate and high risk families about children development and parent functioning.	2a. How many research packages have been completed and what were the characteristics of these families? 2b. How do staff understand the purpose and value of research packages? 2c. How do clients perceive the research process	2a. MIS analysis linking research packages information with RFA. 2b. Interviews with staff about the administration of the research packages. 2c. Interviews with selected clients who have completed some or all of the packages to

Research Activity #1: To inform parents about the opportunity to participate in G.T. research at the time of the initial home visit.

Workers explain to clients the project's research component, as part of their introduction to the program's services. In general, workers felt comfortable with this role.

Since the start of the project, only 26 families have declined research participation, 509 have consented. Those who refused participation in this aspect of the program were largely Tamil speaking mothers who communicated with the assistance of an interpreter. Specific reasons for refusal were not documented by workers.

When there were a small number of families involved in the program efforts were made to assess families on an ongoing basis when their children were one, two, three and four years. These assessments were found to be useful by workers at Growing Together.

Workers introduce the G.T. research component

I do it briefly by telling them the information goes into the computer and helps us know what parents need in your neighbourhood. I also tell them their name will not be used.

Sometimes it's comfortable, sometimes not. Some people are very nervous about doing research.

Workers discuss the benefits of administering research packages

It is important [to do the research packages]. It picks up things you can help with. It was a concrete thing to do with the client and they could see the baby could do something. It was reassuring to parents.

Before it was important [to use these packages to track families]. But now we have the Infant Monitoring System.

I found it helpful clinically and relevant. It clarified my view of the client and the intervention I was using.

Some of the tools were illuminating, like the Ego Functions and it could be used as a spring board. I would like to see it pared down and done by someone other than the clinician.

Research Activity #2: To administer and collect information with moderate and high risk families about children's development and parent functioning.

Research packages were developed for administration with children at 1, 2, 3 months of age, and at 1, 2, 3, 4 years and at the time of termination. The purpose was to monitor the family's risk level on an ongoing basis and examine the child, parent-child interaction, and other sociodemographic characteristics. Because the number of families has expanded so significantly and the program was not successful in obtaining necessary funding for this research, ongoing assessment was discontinued.

According to some workers the research packages helped reassure anxious parents about their child's development and, as well, provided valuable information about parents' functioning to clinicians. Opportunity to track children's development was another benefit of this initiative. The new Infant Monitoring System, however, offers an efficient procedure for accomplishing this same goal. If funding is obtained more intensive monitoring of families will be re-established.

In addition to this research, at any given time, a variety of research projects are occurring in St. Jamestown, both as part of the G.T. project as well as in response to the evaluation requirements of various funding bodies, these have included data collection for the Prenatal classes, the TLC[3] project, CAP-C project, and for the Invest in Kids Foundation.

Clients asked about participating in these research efforts were generally positive about their experiences. The importance of having interviewers who are sympathetic and clinically sensitive is critical for ensuring the well-being of those who participate. The importance of having translators for those whose first language is not English would also need to be carefully considered in future.

Clients talk about research participation

[I was asked questions about] how I feel about the community, what services you use. I was given ten dollars after. She [the interviewer] told me that if I was not comfortable I could leave it [the question]. It was ok. I [also] did the pre-test for the Prenatal Group. They asked about how I feel about pregnancy. It was good to talk to the people here [at G.T].
29 year old, Eritrian Mother of 22 month old.

It [the research] brought up the past and I cried a lot because I could not remember things. I was sad and happy and then I started asking questions [of my parents about the past]. My mom just passed away so I ask my dad lots of questions and that is a good thing for me. ... [During the interview] I was emotional. I had to stop for a while and start again. I felt the person [interviewer] was a therapist sitting there.
43 year old, Canadian Mother of 3, 8 & 20 year olds.

I did pre and post tests for the Groups [I attended]. I liked the interviews. They were not hard. It would be better or easier if it were in Tamil, or it the people [interviewers] could speak Tamil.
29 year old, Tamil Mother of 16 month old.

Some questions I did not like. Some were ok. ... Mostly, I knew the answers. If I did not [know] I asked the person [interviewer] and she explained [the question]. There were too many questions, otherwise it was ok.
36 year old, Tamil Mother of 2 & 5 year olds.

8.3 Summary

A commitment has been made at Growing Together from the beginning, to collect relevant data on families who attend its various programs. As well, evaluations of the program have been carried out, although up to this time resources have not been available to complete a study of the long-term effectiveness of the program in enhancing the capacities of young children in the area.

Because of this commitment to evaluation, the program has a Research Coordinator who is responsible for the Management Information System (MIS), data analysis and the design of research activities. The development of the MIS has been complicated because of the many components of the Growing Together program . As well, the different legislature covering confidentiality issues for the two primary partners, has presented a challenge to the integration of data for some time. Currently, the system can be accessed by staff and the Research Coordinator is in the process of providing MIS training for this purpose.

Valuable information on various aspects of the program is available and the Risk Factor Assessment provides an interesting baseline for families entering the program. With the new *Healthy Babies Healthy Children* initiative, for which Growing Together is a contract agency, it will be necessary to co-ordinate the two Risk Assessments for the new program and Growing Together. The RFA is currently undergoing further consideration as part of this process.

IX Summary of the Study and Recommendations

9.1 Summary of the Findings

The objective of contacting all new mothers residing in the St. Jamestown neighbourhood, in order to promote the G.T. program, is being successfully accomplished by the Program. Eighty-seven percent of new mothers (313 of 359) living in St. Jamestown were telephone contacted by PHNs during the year 1996.

The use of DPH Birth Registration Notices to contact new mothers was the single most successful method for reaching and encouraging the participation of parents. Birth Registration Notice forms, completed by hospital staff whenever a child is born, assist PHNs in the task of identifying and contacting women in St. Jamestown who have recently given birth. Parents consenting to the G.T. program are subsequently referred to and contacted by the G.T. Intake Worker. In 1996, forty-five percent of G.T. clients entered the program through this route of referral. Sixty percent (N=189) of those contacted by PHNs agreed to a follow-up phone call by a G.T. Intake Worker. Of these cases, 92% were successfully reached, of which almost one-half joined the program.

Although 124 parents refused Growing Together services, at the time of initial contact, almost one-half received an initial assessment of infant and maternal health as well as needed interventions from PHNs. Characteristics of families who refused referral to the program and those who agreed were not significantly different, thus confirming the project is reaching a range of families in the community and not simply a select group.

Two-hundred and fourteen children and their families joined the Growing Together program in 1996, resulting in a total participation rate of 477 families and 543 children. Community parents in addition to being recruited through the Birth Registration Notice route, also joined the G.T. program by: self-referral (16%), referral through an outside agency providers (15%), and other or untraceable means (24%).

Background or intake information on G.T. clients has been most thoroughly collected through the completion of the Risk Factor Assessment (RFA) interview. Since the start of the project, five years ago, 535 RFA interviews have been successfully conducted and entered into the G.T. Management Information System.

RFA interviews were usually completed through home visits, which were considered by workers to be an effective outreach strategy for reducing barriers between parents and workers and encouraging a feeling of safety and ease for clients. Workers all indicated that the RFA measure provides valuable clinical information about infant health and development and parent functioning. RFA questions allow workers to delve into a family's health in a complete, organized and consistent manner.

In 1996, one-hundred and six RFA interviews were completed. Similar to other years, the G.T. population fell into the three risk level categories as follows: 56% low, 25% moderate, and 19% high risk. All families from the high risk group and nearly half of the moderate risk group were being followed by G.T. workers and/or Public Health Nurses.

G.T. program initiatives form a continuum which ranges from providing information of various kinds to providing very intensive clinical/counselling interventions to families facing multiple challenges. If the estimated risk to a child is in the moderate to high range, a family receives follow-up from an Infant Mental Health worker or PHN. If low risk, the family is referred to other less intensive services, such as a group, the Infant Monitoring System or Developmental Clinic.

Two-hundred and nine clients received counselling from PHNs during the year 1996 and Infant Mental Health workers provided 69 clients with 1275 therapy sessions. Mothers receiving counselling/therapy services said they learned about their children's development and that worker visits alleviated feelings of loneliness and isolation. Providing one-on-one teaching and support early on in women's parenting life helps to reduce anxieties experienced by new mothers, while promoting critical health education, caretaking skills, and referral for therapeutic or supportive follow-up services. Upon initial contact with PHNs, eighty-eight percent of new mothers reported at least one health concern. Mothers who bottle fed (15%) rather than breast fed their babies reported their choice had largely been due to initial difficulties. Early intervention by PHNs at times of doubt and difficulty is clearly essential. Ninety percent of the nurses' initial visits took place before the infant was 14 days of age. Preventative work carried out during the post-partum period helps avoid the development of more significant problems and mitigates against the need for later intensive intervention strategies.

G.T. groups are a well used service which include: therapeutic, skills and recreation, psycho-educational, community development, and friendship/support groups.. Attended by a total of 229 participants in 1996, parents said they gained support from other members, as well as

valuable knowledge, and skills from group leaders. Child care services, provided 166 children with care while their mothers attend groups.

The Program's infant/child tracking services, the Infant Monitoring System and Developmental Clinic, help parents avoid the need for future intervention while also allowing children with developmental problems to obtain needed services. The valuable nature of the services provided by the Developmental Clinic, in particular, was mentioned by local community service providers, who referred clients to the program for developmental assessments and medical concerns.

Between September 1996 and August 1997, 105 parents of infants and young children enrolled in the Infant Monitoring System (IMS). Clients felt positively about the IMS saying that it helped them to understand their child better. Parents noted that they found the information provided by the Infant Monitoring System to be particularly helpful. It also provided parents opportunity to ensure their child's healthy development while remaining minimally involved in the Program. Eleven percent of the 105 IMS families were solely involved in this aspect of the program. Thirty-one percent of the children being tracked by the IMS were identified as having developmental or health concerns and were referred on to the Developmental Clinic.

Over the course of the Developmental Clinic's history, 332 children have been assessed with 63% of the Clinic's cases having attended follow-up appointments.

During the year 1996, one-hundred and twenty-eight children were seen by Developmental Clinic staff. Over one-half were under 12 months of age at the time of their first visit. Fifty-five percent of the children were identified as having a health and/or developmental concern.

Community Development initiatives compliment the other work being carried out at G.T., and provide valuable experiences for parents. Having a broad range of possibilities for program participation has been successful in meeting the needs of a large proportion of the families in St. Jamestown. During 1996, six community events resulted in the participation of over 1000 community members. Community members have played an increasingly important role in the planning and operation of these events. In partnership with community members, G.T. workers have facilitated and participated in eleven community groups and committees that focus on identifying community needs, organizing for social and political action, and implementing improvement projects. Listening to community members is a key priority of the program, as evidenced by the Computer Skills Training Project which was developed out of women's expressed desire to learn computer skills.

Another aspect of the Program that is particularly important for the community is advocacy services. Within a one year period (1996), 134 families were referred to the project's Community Home Visitor Worker who specializes in advocacy services. Advocacy work is also a significant aspect of other worker's activities which offers assistance to parents with meeting their daily life needs such as, shelter, housing, food, and child care.

Over the years, 25 to 30 students have participated in the G.T. program. Student placements were rated very positively by students and those supervising them. Currently there are 22 volunteers working with the program in a variety of capacities. Students and volunteers make a substantial contribution and feel supported and valued members of the program team.

The G.T. project effectively addresses the multiple needs of its families by virtue of having a multidisciplinary team of workers who possess a wide range of knowledge and skills. Team members rely upon the expertise of one another. Furthermore, team discussion and case consultation result in significant learning amongst workers, contributing toward the development of a transdisciplinary team.

Team meetings are critical to the successful management of cases as they provide opportunity for team members to receive supervision and training, network, consult about cases, and share program up-dates. Workers considered team input into the interpretation of RFA information to be exceedingly beneficial. In addition to team meetings, the MIS allows for the tracking of families and their service use patterns. Clients enter the program in different ways and participate in an array of services, tracking their activities through a complex Management Information System that integrates the information of seven different data sets, is a necessary aspect of the program.

G.T. was considered by local service providers, who referred 33 to 50 clients to the program per year, to be a very valuable service to the St. Jamestown community. They believed clients to be receptive to the relaxed and welcoming atmosphere and felt it appropriate that local ethnic groups were represented on the G.T. team.

9.2 Recommendations

The following recommendations are made on the basis of the Study's findings.

SERVICES

1. Services should continue to be offered at a convenient community site in a welcoming and respectful manner.

Outside service providers felt clients were more receptive to the G.T. program because of its familiar and convenient location and comfortable atmosphere. The clients themselves saw the project site as a sort of 'home away from home' that provided them opportunity to meet other parents and escape feelings of isolation and loneliness. Having members on staff who represent the community's various ethnic groups, (i.e.,Tamil, Hindi, Filipino, Somalian), was seen as an additional asset to the program.

2. The telephoning and offering of immediate services to new mothers by PHNs when Birth Registration Notices (BRNs) are received, is a vital component of the G.T. program.

Compared to at-risk referrals that are being received from hospitals, the Birth Registration Notice method of reaching new mothers, whereby all homes with newborns are contacted, is a far more effective method of reaching new mothers and providing immediate information. The Birth Registration Notice method of contact allows families to receive immediate, preventive intervention and also contributes to the probability that parents will seek out early intervention services from the G.T. program if needed.

3. Home visiting is an effective means for reaching new mothers in the St. Jamestown community and must be continued as it is a vital approach for providing outreach, intake, and early intervention services.

Home visiting was seen as an essential approach by workers because it provides an opportunity to reach hard to access families and service those who are isolated due to being fearful or

mistrustful of community service providers. Furthermore, visiting new mothers at their home is most beneficial to the women who are often still recovering from childbirth and have questions and/or health concerns. As well, workers felt they were able to gather greater information about the needs of families by observing the home environment, parent-child interactions, and general family dynamics. Clients themselves enjoyed the relaxed atmosphere and convenience of having a worker visit them in their home and felt they had benefited greatly from the assistance and support received.

Sixty five percent of first time mothers reported health concerns to PHNs. Therefore, it is essential that PHNs continue to offer home visits to all first time mothers. Furthermore, women rated as being at "extreme risk" and women who had a greater number of children at home, were least likely to breast feed their babies. Therefore it is important to have PHNs more intensively involved in both types of situations for longer periods of time than with low risk families, in order to further encourage breast feeding and help these mothers cope with the added demands of breast feeding.

4. The Infant Monitoring System and Developmental Clinic services should continue to be readily available to families at Growing Together.

It was greatly appreciated by outside community service providers that psychological, speech, medical, and health assessments could be easily and quickly accessed by families in the community. Families themselves were pleased with the opportunity to have their child's development and general health monitored and to attend the Developmental Clinic as needed.

5. Groups must continue to be offered at the program site as they are an important means of encouraging program participation while also providing community members with education, skills, and counselling.

Offering groups that are relevant to the needs of community members has helped to ensure their enthusiastic participation in this aspect of the program. Once attending groups, families can be effectively linked with other services, both at G.T. and in the outside community.

The continued provision of on site Child Care services is essential for parents who have limited support in their lives and therefore could not attend any Groups at the program if it were not for this service.

6. Community initiatives should remain an important priority of the program as these efforts encourage the formation of a collaborative partnerships with the community and encourage G.T. participants to develop new skills and competencies.

Community events play a critical role in making the Growing Together program visible, while bringing together both residents and local service people. Growing Together must continue to collaborate with community members and local service providers in the planning and operation of these events. As each event provides new information about how best to proceed in planning future gatherings, feedback from those in attendance, residents and service providers, should be actively sought.

The general principle of listening to community members about their needs and preferences should continue to be of central importance for the purpose of program planning and development. Efforts to facilitate desired groups, such as the *Crafts Group*, is key to promoting a collaborative atmosphere with the community.

Client consultations and educational sessions, provided by Growing Together workers to outside community services, are an additional means of contributing to the health and well-being of families while also elevating the profile of the program and its services.

FUNDING

7. Sufficient and stable funding must be secured to ensure that the key components of the Growing Together program can be adequately maintained.

The uncertain nature of short-term, contractual funding, the quick turn over rate of students on placement, and the limited time involvement of volunteers, results in a lack of continuity for those working with the program, as well as for those receiving services. Sufficient and ongoing funding would allow for the stabilization of the following three key program component areas:

- the Infant Monitoring System and Developmental Clinic
- clinical/counselling interventions, and
- groups

Specific gaps in the funding of these three areas are described below.

The developmental monitoring of infants and young children through Infant Monitoring System and the Developmental Clinic is of central importance to an early intervention initiative such as the G.T. program. Both are popular services, which are well used and appreciated by the community. Both require additional funding in order to ensure their survival.

Similarly, clinical services at the project are highly stretched due to recent funding cuts resulting in few full-time positions being available at the project.

Groups at the program are continually being developed and implemented to meet the needs and interests of the community. Desired groups, such as the *Father's Group* and *Crafts Group*, require facilitators in order to run effectively. A *Craft Group*, offered last year, experienced considerable difficulties because the group was planned and operated primarily by volunteers who were unable to remain dedicated to the group. While volunteers are a critical aspect of the program, weekly Groups would be made more stable by the payment of leaders. Additionally, it would be optimal to secure funding for hiring child care workers who would be willing to work the necessary hours to ensure parents are able to attend groups without worry or distraction.

Incentives for parents to attend Groups should be available to all those who attend. Currently, only certain group members benefit from incentives, such as food vouchers. It is recommended that all parenting groups put in place an incentive program, similar to that used in the *Prenatal Group,* and include handouts, tokens, certificates and so on, in order to encourage ongoing parenting group attendance while also promoting healthy nutritional practices in St. Jamestown families.

Finally, in addition to stabilizing these three areas additional funds need to be available for future program development. Where needs of the community are newly identified there must be sufficient funds available to give program Directors opportunity to integrate additional services. This would allow strategic planning rather than the current constant reacting to funding initiatives which does not allow the program either to respond to the needs of St. Jamestown families or to plan in a considered manner.

WORKER SUPPORT AND TRAINING

8. The Growing Together team should continue to be represented by professionals from a variety of disciplines in order to meet the multiple needs of the G.T. population.

Growing Together families face many challenges in their lives. Common areas of concern include the isolation and limited support experienced by many new immigrant families, families living without sustenance due to poverty, as well as problems associated with health and medical concerns and/or mental illness. Additionally, families struggle with typical parenting issues and, at times, must meet the needs of children with developmental delays and/or behavioural problems. Growing Together team members require a variety of skills in order to meet families' multiple needs. Team members respect and rely upon the skills and expertise of one another. Communication about topics of interest and case consultation frequently occur, resulting in significant support and learning. Working collaboratively in this partnership has resulted in the development of a very effective multidisciplinary team.

9. Team meetings must continue to be held regularly to provide opportunity for case consultation, networking, information sharing and training.

Meetings provide a critical forum for case formulation, consultation, information sharing, as well as in-service training. Team input into the interpretation of RFA information was found to be exceedingly beneficial for workers. Case consultation is particularly important in those situations where more than one worker is involved with a family. Educational, in-service training, provided at team meetings one to two times a month, was rated by workers as very important. Workers from different disciplines received information on topics to which they would not normally be exposed and ensured workers had a similar knowledge base about the principles underlying program activities. Finally, maintaining a true partnership between the two major partners is enhanced by the regular co-ordination of services that happens at weekly team meetings.

10. Supervision and support of workers seeing higher risk clients should be provided either through team meeting participation, or individual supervision.

G.T. workers, students and volunteers, who are seeing moderate and high risk clients, should receive regular supervision from project Co-Directors during team meetings or individually. Having senior clinicians involved in the supervision of more junior staff and students has been successful and could be examined as an additional way of providing greater support to workers.

11. Continued efforts should be made to guarantee the successful integration of students and volunteers.

Students and volunteers, including volunteers from the St. Jamestown community, have a sense of being an integral part of the team. These team members must continue to be recognized and feel appreciated in their various roles.

Student placement is a positive experience and well utilized service. Workers who provided supervision services to students found the task both manageable and enjoyable. Overall, students' placement experiences were rated as very positive.

Initial training of students and volunteers was addressed in one of two ways: 1) two to three day group training, and 2) an individual plan of introduction to program activities and policy. Much of this variability has depended on the number of people entering the program at any given time, and the availability of people to conduct formal orientation sessions. All staff would benefit from formal orientation training which occurs over the course of a few days.

PROCEDURE AND POLICY

12. Workers need clarification regarding Client Consent forms.

Workers identified a need for clarification on the application and completion of the new Consent to Release of Information form and on the required consents for the completion of the Risk Factor Assessment. In the past, a client's failure to give consent for G.T. research participation, for example, has resulted in RFAs not being completed. Procedure policy must be developed to clarify this issue.

13. Possible revisions to the program's RFA interview are being examined.

Currently the RFA is being revised so as to incorporate areas of interest identified by the *Healthy Babies, Healthy Children's Project* as it will be linked through practice with the G.T. program. Recommendations for revisions will be considered for inclusion by the Co-directors of the program.

14. Accreditation needs of the project should be reviewed with team members.

Further discussion with staff is merited about the accreditation requirements for case review and formulation, once these requirements have been fully determined by the Merger Committee of the Hincks-Dellcrest Centre. Questions regarding who should be present and whether nurses would benefit from participating in a similar discussion should be explored.

15. There is a need to review the program's feedback procedures when responding to both internal and external referrals.

Workers felt the informal networking and consultation system at the project was working well given time limitations, however, workers indicated a desire to increase the feedback received about internally referred clients. Methods for improving worker communication about clients referred on to services within the program, such as groups or the Developmental Clinic, need to be further considered.

Procedures in relation to the provision of feedback to outside service providers regarding the assessment, treatment, or attendance of referred clients needs to be clarified. Communication between services, in both directions, should be improved by ensuring all outside providers understand the need for submitting a *Consent to the Disclosure, Transmittal or Examination of a Clinical Record, Form 14,* when feedback on a referred client is requested.

16. Decisions about the status of the program's research needs to take place.

Frequently, funding agencies require collection of data which places strain on staff and families. Therefore, the time and organization required of workers to administer questionnaires, and the question of whether measures are culturally appropriate and able to accommodate participants

whose first language is not English, are areas needing further consideration by the program Directors.

PROGRAM PROMOTION

17. Methods for reaching more parents in the community should be explored with team and community members.

There was an identified trend whereby parents with more than one child were more likely than single child parents to refuse follow-up visits and referral to the G.T. program. Anecdotally, it is also recognized that mothers of multiple children often express concern regarding older children, up to five years of age, upon receiving a home visit from a worker. If additional funding is available, consideration of additional ways to promote program services to attract parents such as these would be useful for increasing their involvement and ensuring early identification and service provision.

18. More education should be provided about community initiatives.

The relationship between certain community activities and the G.T. program's mandate is not always apparent to community members and service providers. Education about the community development initiatives and its role in early intervention would be important for both outside community workers, residents, as well as for G.T. workers.

19. Backgrounds of students and volunteers that would be most valuable to the program at any given time could be identified so as to implement appropriate strategies for recruitment.

Volunteers learned about the project often by word of mouth or through media publications and pursued the notion of volunteering by speaking directly with one of the Program's Co-Directors. Students heard about the program through teachers, placement coordinators, and other students. The G.T. program is well respected by those referring students and volunteers, and there is significant interest in the training opportunities offered by the program. A coordinated means of promoting the program and campaigning for students and volunteers with particular

skills that are needed by the program, could be initiated by a Volunteer Coordinator from the Hincks-Dellcrest Centre, if such a position becomes available.

THE MANAGEMENT INFORMATION SYSTEM AND STATISTICS

20. Parallel demographic information should be collected at all levels of program entry.

Decisions need to be made at the project about what client background information will be collected and standardized forms developed so that parallel demographic information can be collected at all levels of program entry (i.e., groups, home visits, developmental clinic).

The Toronto Public Health Department files contained a wealth of information about families with newborns living in St. Jamestown. Means for increasing information about fathers, if possible, would be valuable as would clarification regarding the coding of 'ethnicity' and language so a clearer understanding of ethnic breakdown in the community could be obtained. This is important information to collect as it will help to confirm the characteristics of families being served while also providing opportunity to examine whether the program is reaching all segments of the community. The computerization of file information at the DPH will make these data available without the difficult task of a file review.

21. Details about worker activities need to be clearly documented.

It is recommended that the *Individual Intervention Statistics* sheet, completed monthly by G.T. Infant Mental Health Workers, be revised and expanded. Identified problems with the current form are described in the report. Upon re-drafting these *Monthly Statistics Forms* there should be a pilot-testing and review period to ensure the activities of workers are being clearly and fully captured. This work would best be completed no later than December, 1998 so the revised forms can be implemented at the start of 1999.

It is recommended that the specifics of workers' interventions be captured in some manner, as it is not possible to determine through the MIS the number of parents and children receiving therapeutic interventions, the number of parent-child dyads engaged in interactional coaching work, and so forth. The Monthly Statistics Form should be expanded to include the type of

therapy being delivered by workers. Perhaps a check-off key could be added at the bottom of contact page notes for easy completion after each intervention is provided.

As well, workers with specialized roles within the program, such as the Community Development Worker, Advocacy Worker and Child Care Coordinator, could submit statistics on activities undertaken and number of families served. Their submissions should be reviewed and made to correspond as closely as possible to the Infant Mental Health Worker *Individual Intervention Sheet* so that details about the activities of all G.T. workers are comparable.

The monthly activities of PHNs and the program Psychiatrist are currently not available at G.T. Methods for capturing their work in a similar manner could be explored. As already mentioned, the Toronto Public Health Department is currently in the process of computerizing their filing system. Discussion should be undertaken at this stage to ensure G.T. has access to needed information in the future. As an example of one identified gap, it was found that over one-quarter of new mothers in the community did not complete post-natal sheet questions with PHNs over the telephone. However, it would be helpful if nurses would fill in as much information as possible on the post-natal sheet so future review of their activities and interventions would include all those women contacted. Understanding the variety and intensity of services being provided by workers will help to further clarify the model of service delivery and also the staffing and service needs of the program.

22. Information Management System database gaps need to be addressed.

Developmental Clinic Database: In reviewing Developmental Clinic files it was often difficult to identify concerns since Clinic workers do not generally note these details in a way that is clear to those outside the profession. Those reviewing files and entering data into the Management Information System would therefore need to deduce concerns identified in Clinic cases. Developmental Clinic staff should develop a separate standard check off list which would be included in each file. Number and areas of concerns identified by each clinic staff person would therefore be clearly documented for each case.

Client Intake Database: It was not possible to determine through the MIS how a large portion of the 1996 client group initially entered the program. That is, it is not know whether they came to the program through the Birth Notice route, self referral, or outside agency referral routes. Therefore, it is recommended that this piece of information be systematically collected and

entered into the program's data bank. Future program promotion initiatives would be greatly informed by such data.

During the study it was also discovered that it was difficult to track the number of cases entering the program in a particular year. This problem was, in part, related to DPH Referral Forms often missing the date of referral and child's date of birth. Forms were sometimes incomplete because of concern regarding the conveying of confidential information when clients had provided only their verbal consent to be referred to the program. As such concerns have been resolved between the two agencies, workers will be encouraged to fill in the date on all G.T. referral forms. The number of clients joining in a one year period will continue to be an important piece of data to verify the on-going success of the program in reaching new parents in the community.

A third problem identified in this area is related to cases that are not English speaking and who are contacted by someone at the project, other than the Intake Worker. The involvement of other workers may result in contact information not being entered into the Intake database. The program Intake Worker should ensure that all referral forms are returned to the Management Information Coordinator, noting the outcome of the contact attempt so accurate numbers are reflected as to the project's intake contact rate.

Infant Monitoring System Database: Based on the current Management Information System it is not possible to determine what activity a client was involved in at the time of joining the Infant Monitoring System. Future information about a client's route of referral to the Infant Monitoring System would be helpful in determining the best methods for promoting this aspect of the program as well as ensuring promotion is occurring at all program levels.

Additional statistics to be collected: The number of clients referred by G.T. workers to outside services should be clearly documented by all workers as file reviews are an inefficient and inaccurate method for calculating referral and acceptance rates. Again, such statistics provide an ongoing assurance that the program is operating as intended.

While only 26 families have declined research participation, specific reasons for their refusal should be documented by workers and entered into the MIS so as to inform future research recruitment attempts.

It may be helpful to document in team meeting minutes, the number of RFAs reviewed each week in order to further understand the extent of workers' case loads and the operation of the team.

The number of people who attend each community event could be methodically determined by distributing particular pamphlets or other items at the door. The number of items distributed would indicate the number in attendance which is currently based on estimates.

23. All G.T. workers should be trained to use the MIS so they can become familiar with the information available to them.

Workers should be trained by the MIS coordinator on the organization and use of the Management Information System, so they themselves are able to identify the service use patterns of clients.

An ongoing challenge faced by the program is related to the successful integration of client information, which may potentially appear in files in three locations -- Hincks-Dellcrest Centre, G.T. site, and DPH. The internal record keeping policies of both organizations, safety and confidentiality precautions, as well as space restrictions, make it impossible at this time to store all files at the project site. The G.T. Management Information System is therefore critical to the successful management of G.T. cases and should be used maximally to improve case coordination. The Management Information System, however, cannot capture all aspects of worker contact with clients as it is continuously expanding due to community development initiatives and worker outreach. Additionally, PHN case involvement is currently not documented at the project making it extremely difficult to know when consultation should be occurring. In combination, worker use of the MIS and team meeting consultation allows for case information to be shared.

9.2 Conclusion

The Growing Together program began in 1993 with $7,000.00 and use of a small room at Cabbage Town Youth Centre, operating from 9am to 4pm. Since that small beginning, the proposed model for the program has been successfully implemented, new program space has

been developed, and the program is meeting the needs of an increasing number of families with infants and young children in St. Jamestown.

The information from this process evaluation has confirmed that the essential components of the model are meeting the needs of families and are well accepted by workers. Study recommendations will increase the program's capacity to maintain adequate records of the various families that use the program and the interventions that they receive.

In considering any possible lessons from the beginning of the program to its current operation, the following would seem to be critical, that:

- A considerable period of preplanning is important that allows the model to be conceptualized, a needs assessment to be carried out and staff to be oriented.
- Having goals and objectives developed with the participation of staff is crucial.
- The theoretical model should be articulated from the beginning and should form the framework on which to build the service structure.
- Policies and procedures be drawn up early with team participation and made available to the team for continual reference.
- A Management Information System (MIS) should be put in place as early as possible, gradually built on and constantly monitored to assure that it is capturing information and statistics to reflect the complexity of the program.
- Staff training about various interventions is crucial at the beginning and on an ongoing basis.

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